			. For	State of M	-	-		lealth and M	lental Hy	giene	0.00	ATS 1000 1000 ATS
			1 - State Registrar		(Certific	cate of	Death		Reg. No:	JUD	0/501
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	Funeral Director		5. Social Security Number 6. 457 02 12/6 Usual Residence of Decedent	1 M 2 □ F			nths Days	Hours Min.	8. Date of Bir (Month, Da 11/1/1	iy, Year) 954	Coui	olace (State or Foreign ntry) sylvania
	yland Jow		10a. State 10b. County		10c. City, Town	or Location)					10d. Inside City Limits
	a-feh	ctor	Maryland Cecil	L	Perry	ville	.		_			1 XYes 2 ☐ No
	3a or 28	i Dire	10e. Street and Number 509 Aiken Ave.			10	f. Zip Code 219	003		10g. Citizen	of What Cou	ntry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f ahow ovent. I're Micdical Examiner must be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Armed Forces? 1 XYes 2 I If Yes, Give Year or Dates			ecedent of H specify Cuba es 2000	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Wh	etc.
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Maryland		To Be (17. Father's Name (First, Middle, Last John C. Jackson					18. Mother's Name Olivia	e (First, Middle 1 Irene	,	,	
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nor	0 0		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Maryla	nd Ve	or other place terans	(e)	/2005		ock, M	
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.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		pic pregn <i>a</i> ncy er (specify)	1		23d	. Date of delive Month	ery Day Year
<u>α</u>	luires that n signed b	by	Part II. Other significant conditions	contributing to death t	out not resulting in	the underly	ring cause giv	en in Part I.	23e. Did 1	:		he cause of death?
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Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} 2 \subseteq \subseteq \text{No} \)	Hospital:	ent 2□ER/Out	nationt 3	□ DOA Dth	er: 4 ☐ Nursing Ho			Other (Specif	(v)
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Division	of or Attendition of a ster death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of in	jury - At home, far ic. <i>(Specify)</i>	m, street, fa	actory, office		28f. Location (City or To	Street and N wn, State)	lumber or Rura	al Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funaral Director:	edical C		Physicien: To the best eminer: On the basis of and manner st	of examination and							
	Z To th To th comp	Me	29b. Signature and title of certifier	MD			29c. Licens	e number		29d. Date s	igned (Month,	Day, Year) 8-2005
	1.03			/ V	d	Torre Delevi	•					

State Registrar

d cause of death (Item 23a) (Type, Print)

10 N CREENE STREET BALTIMURE, MD 21201

3 Registrar's Signature

Show & Species

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Tark ames 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver S monts 2501 pring Ome is 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Floreign **Funeral** 1□M XXF Days VIRGINIA Director 577 30 3288 85 FEB. 1920 15, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or parter any injury or other treumating. nd Mental Hygiene. marked other than "natural", or flems 23a or 28a-f show imatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥X Yes 2□No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8201 SIXTEENTH ST. #214 20910 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣121 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: BLACK Be Completed by XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12TH HOMEMAKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALMA (UNKNOWN) BENJAMIN JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACKSONVILLE, FL 32208 EDWARD NELSON / SON 8126 PAUL JONES DR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 2/25/05 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. Mary 4308 SUITLAND ROAD SUITLAND, DM 20746 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner sete has been signed by the attending physician end page 2 should be detached for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Ď 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificete 1 🗆 Yes 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No Certification: To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter deet Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours e 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. anature and title of certifies 2001 medical Silver Spring momo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER MO DME 31. Date filed (Month, Day, Year) FEB 2 2 2005 Registrar

			State of Maryland / Department of Health and Mental Hygiene
			- State Contificate of Death 2005 07503
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physicia		MAUREEN MARYANN KENTNER FEBRUARY 19,2005 1:40P M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		·	FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		134-05-1418 NOV. 18, 1920 New York
	and **		Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits
	Manyl f sho	ō	1 Type 25 No
	the 28a-	rect	Maryland Frederick Frederick 106. Street and Number 107. Zip Code 109. Citizen of What Country?
	within 72 hours after death with the Maryland ene. than "natural; or items 23e or 28a-f show he Masical Examiner must be notified at	Funeral Director	5955 Quinn Orchard Rd./ Apt. 209 21704 United States
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
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ဋ္ဌ	ural',	Completed by	3 □ Widowed 4 □ Divorced Specify: Specify: Specify: White
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12	within	m du	Elementary/Secondary (U-12) College (1-40r 5+)
70	Hygie ther int,	ပိ	12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
and	d be antal	э Ве	Daniel Malarkey Marie Horn
Maryland	shoul mark masti	L L	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	nd 2 alth eath er trau		Eileen K. Long / Daughter 2509 Bear Den Rd./ Frederick, Maryland 21701
ē,	s 1 a f Hea item othe		20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health end Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		12 Burial 2 Cremation 3 Removal from State Arlington Nat'. Cem. 03/15/2005 Arlington, Virginia
att	permit. Departn Importa any infu		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A.
<u>m</u>	80 E # 8		Maymond Selenson 1621 Opossumtown Pike/ Frederick, MD 21702
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition) a. FNdSHage Congestive heart failure Onset and Death Sygans
П	/Medical Examiner		Due to (or as a copsequence of):
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury
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760,	ate be executed hysician and he burial-transit	cal	d
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Вох	death certifica e attending ph id for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy
0.	0 0 0	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown Month Day Year
<u>Ч</u>	that the death ned by the atter detached for u		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
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		င္ပေ	Unal Moufficiency 1 Yes 2 No 1 Yes 2 No
Vita	Physician: this certificated all director.	o B	25. Was case referred to medical examiner? 1 Yes 2 DN6
Ö	Attending Physician: or death. ector: After this certific by the funeral director.	-1	27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
0	uttendin death. ctor: Aft y the fun	atlo	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No
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	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edlcal	29a. Certifier (Check only (Check only and due to the cause(s) and manner as stated. (Check only a Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	thin 2 o the omple	Mec	one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
	F 3 F 8		
	10		30. Name And, address of program pleted cause of death (Item 23a) (Type, Print)
	C.		10. Name And, address of p (sor who per pleted cause of death (Item 23a) (Type, Print) His D. AF rook Tell 300 West 9th Street Frederick, MD
	Sta	_	31. Date filed (Month (13) B(eq.) 2 2005 32. Bustrar's Signature 4
	Registr	ar	

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Manyland / Department of H	ealth and Mental Hygiene

			State of Maryland / Department	artment of Health and Mertificate of Death	ental Hygien	
	0		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		OLA MAE KNUCKLES		February	16,2005 2:45A M
	Examin	er	4a. Fecility Name (If not institution, give street and number) BERLIN NURSING & REHABILITATION CIR.	4b. City, Town, or Location of Death BERLIN		c. County of Death WORCESTER
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216–60–7525 1 MXX 88 Yrs.	Months Days Hours Min.	8. Date of Birth UNE 26, Yea	'916 Sinthplace (State or Foreign Country) VIRGINIA
	D		Usual Residence of Decedent			
	show	ក	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits 1 Tyes 2 TyNo
	the A	rect	MARYLAND WORCESTER BERLIN 10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	th with 23a or	alDi	51 DEEP CHANNEL DRIVE	BERLIN	Ţ	NITED STATES
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumette event, the Medical Examinat must be notified at ODGe.	by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 3 □ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes X☐ No Specify:	city Yes or No- tican, etc.)	14. Race - American Indian, Black, White, etc. Specify: AMERICAN TNIDTAN
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ylar	Menta Menta arked etic e	ToE	CHARLES JOHNS	GALLIE J		
, Maryland	and 2 sh alth and 1.27 is m er traum			ng Address (Street and Number or Rural DEEP CHANNEL DRIVE,		
Baltimore,	Pages 1 annual of He ant: If iten	1	20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) 20b. Place of Disposementary, creations,	matory or other place)		Location - City or Town, State LEN BURNIE, MD
Balt	permit. Departr Importa any inje		21. Signature of Funeral Service Licensee	YERS-DURBORAW FUNER 1 WILLIS STREET, V	RAL HOME, WESTMINSTE	P.A. ER, MD 21157
I			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.	0 0	_	Approximate Interval Between Onset and Death
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Δ.	sign sign	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deal Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a westigation, in my opinion, death occurre	nd due to the cause ad at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
)	To within	Ž	29b. Signature profitte or certifier	D28269	29d. [Date signed (Month, Day, Year)
	3		60. Name and address of person who completed cause of death (Item 23a) (Type, NOUNCES N. Borodulcu, N.	Print) 1209 Coa	stal 1	De 1/99441
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 8 2005	bearle	/	

		For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of			ene 1. N2 11 11 5	07505
Physicia		1. Decedent's Name (First, Middle, Las Shirley Krieg					2. Date of Death Month Februar	Day Year	3. Time of Death 5 5:40 p. M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea Frederi	th .ck
Funeral Director		5. Social Security Number 6. S 578-26-0410 Usual Residence of Decedent	ex 7. Ag □ M 2 D F 8	ge (In yrs. last birthday O Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 7, 1	(ear) 9. Bin Co 1924 Wash	thplace (State or Foreign buntry) Lington, D.C.
Maryland I-f show	tor	10a. State 10b. County Maryland Frederic	k	10c. City, Town or L New Mark					10d. Inside City Limits
th with the	al Direc	10s. Street and Number 6937 Fox Chase Ro	ad		10f. Zip Code 21774		100	g. Citizen of What Co U.S.A.	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event. The Modical Exeminer must be multilized at ORGS.	Completed by Funeral Directo	11. Marital Status 1 Newer Married 2 Married 3 2 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{P} \) If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub	dispanic Origin? (Si an Mexican, Puerto Specify:	pecify Yes or No- po Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
i within 72 ho iene. r than "natur i're Medical	ompleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+) (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire etary	during most of work	king	6b. Kind of Business S. Govern	
ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last, William Cisse	1			Claire			
and 2 she ealth and m 27 is m		19a. Informant's Name/Relationship (Kevin Krieger – s	**	6937	Fox Chas		New Market	City or Town, State, . t, Marylar	nd 21774
Pages 1 ment of H tant: If Itel		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)	y)	Frederic	ematory or other pla k Cremato	ry 2/17/	'2005 F1		Maryland217
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requires that the der een signed by the a nould be detached f	d by Pl	Part II. Other significant conditions of		but not resulting in the	underlying cause gr	ven in Part I.		accoluse contribute to	o the cause of death?
The law ate has b	Complete	ALZHEIMERS	AEMENT.	PA			24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
Physiclan: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		SIIL JUDOA	her: 4 Nursing H	ome 5 Residen	nce 6 MOther (Spe	scity) DESIDENCE
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification:	1 X Natural 5 Pending investigatio 3 Suicide 4 Homicide 5 Pending determined	(Month, Da	ujury - At home, farm, s tc. (Specify)	M 1	Yes 2 No		eet and Number or R	lural Route Number,
te Hospita 124 hours ne Funeral	edical C	29a. Certifier (Check only one) Certifying Property Medical Example 1	niner: On the basis of and manner s		nvestigation, in my	opinion, death occu	rred at the time, dat	te and place, and du	e to the cause(s)
To th To th	Me	29b. Signature and title of certifier	Connor	MO	29c. Licen	se number	290	d. Date signed (Mon.	th, Day, Year) 10 21701
9		30. Name and address of person who	completed cause of	death (Item 23a) (Type	CV, SEVE	ENTH ST	FREE	VERLICK A	10 21701
Sta		31. Date filed (Month, Pay, Year)	005 32. Regist	rar's Signature	Grant .		/		

		1 - For State Registrar		artment of Health and rtificate of Death	Mental Hygien	4000	07506
Physi		1. Decedent's Name (First, Middle, Last) Carl P. Krize				Pay Year 17 2005	3. Time of Death 10:07 A ^M
/Med Exam		4a. Facility Name (If not institution, give street and Genesis Eldercare	d number)	4b. City, Town, or Location of Deal Towson	th 4	tc. County of Death Baltimor	
Funera Directo		5. Social Security Number 187-10-4454 6. Sex	F 85 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birth Cou Penr	nplece (State or Foreign Intry) Isylvania
CLIZISHOUS after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. Whyer then "natural", or Items 23e or 28e-f show ont, the Modical Exemples must be notified at	Funeral Director		e Decedent Ever in U.S. 13.	Ellicott City 10f. Zip Code 21043 Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Un Specify Yes or No-	citizen of What Cor ited Stat	CES
A L Z I D-UU SO ed within 72 hours after giene. er then "naturel", or Ite the Moltor Exemine	Completed by Fur	1 ☐ Never Married 2 ☐ Married If Ye \$ Widowed 4 ☐ Divorced Year 15. Decedent's Education (Specify only highest grade comple	res 2 No 1943 – s, Give or Dates: 1945	1 ☐ Yes X☐ No Specify: dent's Usual Occupation kind of work done during most of wo DO NOT use retired) ne Tool Sales	orking 16b.	Specify: Whi	ite Industry
S d a d s	To Be Co	17. Father's Name (First, Middle, Last) Anton Krize		Anna Ka			
Itimore, IN it. Pages 1 and 3 ritment of Health ritant: If itam 27 njury or other tr	0000	19a. Informant's Name/Relationship (Type, Print Carl P. Krize, Jr. 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	39 S 20b. Place of Disporterm State Good She	matory or other place)	ke Rd. High Date 200. 22-05 Ell	land NY Location - City or Licott Cit	12528 Town, State ty, MD
Physicia /Medica Examine	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	that caused the death. Do not en e on each line. PNEUMONI Le to (or as a consequence of): CORONAR Let (or as a consequence of):	ter the mode of dying, such as cardia	DIS		Approximate Interval Between Onset and Death O
by the attending private of the attending priv	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of dei Month	ivery Day Year
rdS, P.O. quires that the n signed by the	þ	Part II. Other significant conditions contributing	g to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacc		the cause of death?
I HECOLG The law requir ate has been si page 2 should I	Completed				24a. Was an autopsy performed	death?	utopsy findings available completion of cause of 2 No
Division of Vital Records, P.O. Box 68/60, for Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be	1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b. Time (Injury)	ont 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No	Home 5 Residence 28d. Describe how i	injury occurred	
	al Certifi	4 Homicide determined 288.	Place of Injury - At home, farm, si building, etc. (Specify) To the best of my knowledge, dea	oth occurred at the time, date and pla	City or Town, S	itate) e(s) and manner a	s stated.
To the Hospitel or within 24 hours after To the Funeral Director completely filled in	Medical	2 Medical Examiner: On and 29b. Signature and title of certifier S Sup	the basis of examination and/or in the manner stated.	29c. License number	curred at the time, date	Date signed (Moni	th, Day, Year)
3) DO	State	30. Name and address of person who complete SMAKWMMACA Ca 31. Date filed (Month, Day, Year)	d cause of death (Item 23a) (Type	o Box 6303	ELUCOT.	7 (177	21045
	State istrar	FEB 2 2 2005	32. Registrar's Signature	parle			

Registrar

State

31. Date filed (Month, Day, Year) MAR - 2 2005

· TC.

32. Registrar's Signatur

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN

H06

111 Penn Street

Baltimore, Maryland 21201

K0110	121215-0036
z X	Maryland 21
Willia	Baltimore, N

	1	State Registrar	Cert	ificate of Death		Reg.	No. UU	Ű_	0/508
		Decedent's Name (First, Middle, Last)				Date of Death Month	Day Ye	ear	3. Time of Death
Physician /Medical		William Richar	d Kolt	o, Jr.	re	bruary	20,20		6:50 A M
Examiner		4a. Facility Name (If not institution, give street and number) Doctors Community Hospital		4b. City, Town, or Location o Lanham			4c. County of I	Geo	
Funeral Director	5	5. Social Security Number 6. Sex 7. Age (In yrs. last $203-26-5473$	t birthday) Yrs.	If Under 1 Year If Under 1 Months Days Hours	Min. Ma	Date of Birth Month, Day, Yo r. 24,	1934 Pe	Birthpla Count nns	ace (State or Foreign ry) ylvania
p P	-	Usual Residence of Decedent 10b. County 10c. City,	Town or Loca	ation				10	d. Inside City Limits
Maryla f sho		Md. Prince Georges		owie					1 Yes 2 No
the h	3	10e. Street and Number		10f. Zip Code		10g	. Citizen of Wha	at Count	try?
h with	3	12410 Melody Turn		20715			USA		
iffer death with the Mar it items 23s or 28s-1 si instrmet by ristiffical		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	1 13	as Decedent of Hispanic Ori Yes, specify Cuban, Mexican	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)	14. Race - Black,	America White, e	
urs a	2	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Neuron 1956-1956 Never Married 1960		☐ Yes 2 No Specify:			Specify:	√hit	e
72 ho		15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation and of work done during mos	t of working	16	b. Kind of Busin	ness/Ind	lustry
ed within 72 ho ygiene. her than "natur. t, Ite Maulcal.		Elementary/Secondary (0-12) College (1-4or 5+)		омот use retired) sman-Retail S	Sales	He	ealth &	Bea	uty Aids
be filed to their dother, the went, the		17. Father's Name (First, Middle, Last)	5420			irst, Middle, Ma	iden Sumame)		
wuld be Mental Mental Mrked o		William R. Kolb				ed Favi			
d 2 sho th and N 17 is ma trauma		19a. Informant's Name/Relationship (Type, Print) Bernadette Kolb - Wife	19b. Mailing 12410	Address (Street and Number) Melody Turn,	er or Rumal Ro Bowie	oute Number, C e, Mary	City or Town, St. land 20	ate, <i>Zip</i> 715	Code)
s 1 an f Heal item 2 other	-	20a. Method of Disposition	ce of Dispos	ition (Name of atory or other place)	Date	20	c. Location - Ci	ty or To	wn, State
Page nent o				ns Cemetery ()2-25-(05 Cr	ownsvil	1e,	Md.
Datulition Dermit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensea		Name and Address of Facili 512 N.W. Crain			ral Hom		20715
40244	+	23a, Part1. Enter the disease, or complications that caused the death.						and	Approximate Interval Between
Physician		shock, or heart failure. List only one cause on each line.		14ELOMA					Onset and Death
/Medical		Due to (or as a conseque	ince of):						
Examiner		Sequentially list conditions, b. Due to (or as a consequence)	101	IA				_	
	j j	cause. Enter Underlying Cause (Disease or injury	ince or).						
executed an and rial-transit	ZYGI	that initiated events c. resulting in death) Last Due to (or as a consequence)	ence of):						
	edical	d						-	
ertifica	Zee -	IF FEMALE: 23c. If yes, outcome of pregnan	01/				23d. Date	of dollar	201
BO Beath c attenc for us	Clar	in the past 12 months?	death 3	Ectopic pregnancy Other (specify)			Montl		Day Year
oy the ached	Fnysician	1 Yes 2 No 9 Unknown							
. = 00	y y	Part II. Other significant conditions contributing to death but not result	ting in the un	derlying cause given in Part	l.				ne cause of death?
	ered Sted					24a. Was an		_	
Hecords he law requires has been sign ge 2 should be	Completed					autopsy perform	ed? de	ath?	psy findings available mpletion of cause of
	000	25. Was case referred to medical		26. Plac	e of Death (C	1 ☐ Yes 2) Check only one		_ Yes	2 No
	0	examiner?	R/Outpatien	t 3 DOA Other: 4 N	ursing Home	5 🗌 Residen	ce 6 Other	(Specif	y)
		1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe hov	v injury occurre	j	
INTISION Tor Attending after death. Director: After Lin by the fune	car	2 Accident investigation	ne farm stre	M 1 Yes 2		. Location (Stre	eet and Number	or Run	al Route Number,
ospital or Atten hours after death uneral Director: ly filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)		,		City or Town,	State)		
Hospi 4 hou Funer ely fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinating and manner stated.	rledge, death on and/or inv	n occurred at the time, date a vestigation, in my opinion, de	nd place, and ath occurred	d due to the cau at the time, dat	use(s) and man te and place, ar	ner as s nd due t	tated. o the cause(s)
within 2. To the I	Med	29b. Signature and title of certifier		29c. License number		29	d. Date signed	(Month,	Dey, Year)
		Paro au		D0057	-63	6	2/20	10	5
(5) Wa		30 Name and address of person who completed cause of death (Item	23а) (Туре,	Print) I aurel Md	20	707			
Stat		31. Date filed (Month, Day, Year) 2. Registrar's Signat	uro.						
Registra	r	FEB 2 2 2005 Frank	Appa						

DHMH 17 Rev 1/2001

			_ State	State of Maryland / I	Department of H Certificate of L			711115	07509
			Registrar 1. Decedent's Name (First, Middle, Last)		Continuate of L		Reg. Note at the of Death	0. • • • •	3. Time of Death
П	Physicia			onny.		E	1	y 18 200	.01.17
}	/Medic Examin		<u>Charles Joseph &</u> 4a. Fecility Name (<i>If</i> not institution, give si		4b. City, Town, or	Location of Death		County of Death	7
			SAINT AGNE	S HEALTHCAN	DE BA	LTIMORE			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	Months Davs	If Under 24 Hrs. 8. D. Hours Min. (A	ate of Birth fonth, Day, Yea	r) Cou	place (State or Foreign intry)
	Director	-	098-12-5001 Usual Residence of Decedent	81	Yrs.	Dec		23	NY
	land		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	Many -1 sh	ţō	MD Baltimore	Cator	sville				1 □ Yes 2√QNo
	r 28a	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	intry?
	th wit		709 Maiden Choice	Lane	212	228		USA	
	r dea	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?		ispanic Origin? (Specify) In, Mexican, Puerto Ricar		14. Race - Amer Black, White	
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 📉 Widowed 4 ☐ Divorced	1X) Yes 2 □ No 1943 - If Yes, Give	1 ☐ Yes 2 💢 No	Specify:		Specify:	
21215-0036	filed within 72 hours after death with the Maryland hyglene. ther than "natural", or tlems 23a or 28a-f show int, the Medical Examinat must be notified at	ed b	15. Decedent's Educ	Year or Dates: 1946	. Decedent's Usual Occup	ation	16b	W: Kind of Business/I	nite
15	in 72 n "na	Completed	(Specify only highest grade		(Give kind of work done of life. DO NOT use retired	during most of working	100.	Tana or Basinosa.	, addity
212	d with	E O	Elementary/Secondary (0-12)	-		st	U.	S. Govern	nment
	al Hy d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First	t, Middle, Maide	n Sumame)	
yla	Ment Ment arkec	2	Charles Joseph Ker	nny		Susanne B.	Gallag	her	
Maryland	2 short and ls m		19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street a				
	1 and lealth sm 27 ther t		Charles J. Kenny .		5503 44th Ave of Disposition <i>(Name of</i>	enue, Hyatts		Maryland Location - City or 1	
ğ	nt of 1		1 🔀 Burial 2 □ Cremation 3 □ Re	emoval from State cemete	ery, crematory`or other plac	ce)		5000	
Baltimore,	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-1 show any njury or other traumatic svent, the Medical Examinat must be rotified at ODGs.		 4 □Donation 5 □ Other (Specify) 21. Sign of Funeral Service License 		of Heaven Ce	m. Feb. 23, ^{ss of Facility} Gasch	AND THE RESERVE OF THE PARTY OF	lver Spr	
Ba	Departing Support		V/1/2 to the	M1373		imore Avenue			
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do					Approximate Interval Between
W	Pnysician		Immediate Cause (Final disease or condition	N. n. n	100				Onset and Death
/Medical			resulting in death)	ue to (or as a consequence	of):	1 0	n n 1		- JUNIA
	Examiner		Sequentially list conditions, b	Conges		art F	acilka	re,	2 years
	pe tis	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				1
_	xecut and il-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	of):			-	
8760,	cate be executed physician and the burial-transit	dical E							
687		0							
Вох	death certifi e attending p id for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal deat	h 2 Estopia prognana			23d. Date of deli	very
	death	by Physician/M	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	h 3 Ectopic pregnancy 5 Other (specify)	<u></u>		Month	Day Year
P.0	that the de led by the detached	Phy	9 Unknown					72/2/12	
			Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did tobacco		the cause of death?
Vital Records,	The law requires ite has been sign bage 2 should be	Completed					-		
3ec	e taw has t	mpi					24a. Was an autopsy performed?	prior to c	topsy findings available ompletion of cause of
a			25. Was case referred to medical	- · · · · · · · · · · · · · · · · · · ·			I Yes 2 →		2 No
-	Physician: this certific ral director,	o Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/C	Putpatient 3 DOA Oth	26. Place of Death (Ch er: 4 ☐ Nursing Home		6 ∏Other (Spec	eifv)
of		-	27. Manner of Death		Time of lnjury Wor		Describe how in		,)
lor		atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Fear)		Yes 2 □ No			
Division of	or Atterdender de Directorin by ti	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, in building, etc. (Specify)	arm, street, factory, office		ocation (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	Hospitel of the policy of the					<u> </u>			
	• Hospitel or Atten 24 hours after deatl • Funerel Director: etely filled in by the	edical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medicel Exemir one)	icien: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the tir nd/or investigation, in my o	ne, date and place, and o pinion, death occurred at	lue to the cause the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospitel or Attenwithin 24 hours after deation to the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. [Date signed (Monti	Day, Year)
)			> Albaria.	an in	P186	509	Feb	ruary 19	. 2005
6	(11)		30. Name and address of person who co	mpleted cause of death (Item 23a	(Type, Print)		_		
1	(1)		DANTEL.	ABRAHAM _	, 900, ca	ton, Ave,	Balt	more, R	10 21299
; ·	Sta		31. Date filed (Month, Day, Year) FEB 2 2 2005	. Registrar's Signature	Liki	ŕ			
	Registi	al	F L. B 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	DOBLE JE	STATE OF THE PARTY				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 21 2005° **Physician** 7:30 A Robert Α. Lauffer /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 12605 Millstream Drive Bowie If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. Min. May 29, 19 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F 84 Yrs. 1920 Director 189-14-6802 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a, State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Madical Examinar must be notified at 1 AYes 2 No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20715 12605 Millstream Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dr. William M. Lauffer Laura Ayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Gary J. Lauffer / Son 12605 Millstream Drive Bowie, MD. other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. MD. Veterans Cemetery 03/04/2005 Cheltenham, MD. ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final **Physician** 3 MON YH disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated words.) Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 5 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 XNo 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Venkatraman, M.D. 6201 Greenbelt Rd. #U3 College Park, MD. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 2 2 2005 Registrar

		1 - For State Registrar		Marylar	-	artmen rtificat			ind M	ental Hyg	iene eg. No:	005	07511
Physici		Decedent's Name (First, Middle, La. Ronald	st)		Lind	beck				2. Date of Deat Month February	Day	Year 2 <i>005</i>	3. Time of Death
/Medic Examin		5. Social Security Number 6. S	Kiùs A	tospi-	la (last birthday)	13.4 If Under	Himi 1 Year	If Under 2	City 24 Hrs.	8. Date of Birth (Month, Day,	4c. C	ounty of Death	nplace (State or Foreign
Director		077-36-6634 Usual Residence of Decedent	№ 2□F	58	Yrs.	Months	Days	Hours	Min.	Jun 25,	194	Col	ifornia
ie Marylan 8a-f show	Director	10a. State 10b. County Maryland Balti	more	10c. Ci	ty, Town or Lo	ocation		Upp	erco				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with th	al Dire	10e. Street and Number 16636 Trenton Ro	ad			10f. Zip	Code	211	_55	1	0g. Citize	n of What Co USA	untry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland in of Health and Mental Hygiene. If flem 21 is marked other than "neturel", or items 23a or 28a-f show or other treumatic event, the Maryleal Examiner must be notified.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? 2⊠No	İ	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto f	cify Yes or No- Rican, etc.)		Race - Amer Black, White pecify: Wi	
d within 72 ho giene. or than "netur II e Madical	Completed	15. Decedent's E. (Specify only highest gra	de completed) College (1-	4or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us Banl	rk done d se retired	ation luring most)	of workir	ng		of Business/I Bankin	,
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, It a Manne.	To Be C	17. Father's Name (First, Middle, Last, Eric Victor Lir						Flo	oreno	(First, Middle, M Ce Rose)	.yn F	'isher	
and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Susan M. Lindbed								Route Number			ip Code)
Pages 1 ann of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		state	Place of Dispo cemetery, cre rist L	matory or o	ther plac			1.		tion - City or T	
permit. F Departm Importar any injur		21. Signature of Fureral Service Lice		M00723		2. Name ar	d Addres	s of Facility	E	line Fur , Hampst	neral	Home	Search -
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Sept. Due to (c	sch line. Si S or as a consec	quence of):		ncer	g, such as c	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death 2 Weeks
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	_d. 23c. If yes, outo 1 □ Live bi	come of pregn	ancy al death 3[□Ectopic pi					23	d. Date of deli Month	very Day Year
uires that the death cer signed by the attendir d be detached for use	y Physi	1 Yes 2 No 9 Unknown	9□ Unkno	wn			,,	en in Part I.		23e. Did tol	pacco use	contribute to	the cause of death?
w requires been sig should be										1 □ Ye	s 2 🗆		obably 4 Junknown topsy findings available
icien: The lav certificate has ector, page 2	e Completed	OS Was assessed as a first fir								autops perform 1 Yes	ned? 2 No	prior to death?	ompletion of cause of
ysicie is certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	patient 2] ER/Outpatie	nt 3 DC	Othe			(Check only on ne 5 ☐ Reside		Other (Spec	cify)
Attending Physicien: The lar ar death. ector: Alter this certilicate has by the funeral director, page 2		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		f Injury o, Day Year)	28b. Time o Injury	of 2	28c. Injury Work 1 🗀 '	rat ⟨? Yes 2 □ N		8d. Describe ho	ow injury (occurred	
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place buildin	g, etc. (Speci						City or Town	n, State)		ral Route Number,
To the Hospitel or within 24 hours afte To the Funerel Discompletely filled in	edical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Example)	nysician: To the miner: On the ba and mann	sis of examin	owledge, deat ation and/or in	h occurred ivestigation	at the tin	ne, date and pinion, deat	d place, a h occurre	and due to the ca	ause(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)
Withi Somy	×	29b. Signature and title of certifier	Mat			290	License	number S-00	0	1		signed (Month	
Mis		30. Name and address of person who	completed cause		m 23a) (Type,					rtimor	E, M	MIZYLA	15, 2005 ND 21287
Sta		31. Date filed (Month, Day, Year)		gistrar's Sign		/					-		•

			1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and I Death	R	eg. No.	0751	2
	Physicia /Medic		Decedent's Name (First, Middle, Last) GEORGE WILLIAM LIN	ZEY				2. Date of Deat Month FEBRUA	Day Ye		eath A _M
	Examin		4a. Facility Name (If not institution, give str 1508 PLEASANT VALL)	EY ROAD		4b. City, Town, or OAKLAN	D		4c. County of D		
	Funeral Director		5. Social Security Number 218-14-5461 6. Sex 1⊠th 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. la	Ven	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 9. /1923	Birthplace (State or F Country) MD	Foreign
	Maryland -f show	tor	10a. State 10b. County MD Garre		Town or Lo					10d. Inside City 1 ☐ Yes 2	
	a or 28a or 28a	i Directo	10e. Street and Number 1508 Pleasant	Valley Road		10f. Zip Code 215	50	1	0g. Citizen of What	t Country?	
336	within 72 hours after death with the Maryland ene . then "netural", or tlems 23e or 28es-f show fa Madical Exeminer must be motified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? ▼ Yes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 (\$\frac{1}{2}\text{No}		pecify Yes or No- o Rican, etc.)	Black, V	American Indian, Vhite, etc. Caucasia:	n
21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or items 23a or 28a-f show event, if a Madical Execution must be notified at	Completed	15. Decedent's Educa (Specify only highest grade: Elementary/Secondary (0-12)		(Give life. I	dent's Usual Occupa kind of work done o DO NOT use retired	ation furing most of wor)	rking	16b. Kind of Busine	ess/Industry	diti
ō	should be filed vand Mental Hygies marked other tumatic event, It	To Be C	17. Father's Name (First, Middle, Last) Harry Linzey		FO	Leman		me (First, Middle, I	Maiden Sumame)	, , , , , , , , , , , , , , , , , , , ,	<u> </u>
Maryland	nd 2 shou alth and M 27 Is mar r traumat	-	19a. Informant's Name/Relationship (<i>Type</i> Doris Mary Li			ng Address (Street a				te, <i>Zip Code)</i> and, MD	2155
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Monta Important: if item 27 is marked any injury or other traumatic a once.		20a. Method of Disposition 1			sition (Name of matory or other plac Cemetery	02	Date / 23 / 200	20c. Location - City 5 Gale:	or Town, State	
Balti	permit. Departmit.importa any inju		21. Signature of Funeral Service Licensee		22 I	E Name and Address , STO W. CV	s of Facility Helfer	nbein & St Mill	Newnam	Funeral	Hom 1
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicions shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	e cause on each line.	. Do not ent	er the mode of dying	g, such as cardiae	or respiratory arr	est,	Approximate Interval Betwe Onset and De YEARS	en
8760,		ical Examiner	Sequentially list conditions, if any, but ing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Ye	ar
	uires that signed by Id be deta	by	Part II. Other significant conditions cont	ributing to death but not resu	ilting in the u	nderlying cause give	en in Part I.			te to the cause of dea	_
l Records,	The law requir ate has been si page 2 should I	Completed						24a. Was a autops perform	sy prior		ailable se of
on of Vital	Attending Physician: The r death. ector: After this certificate h. ector: After this certificate h. by the funeral director, page	To Be	27. Manner eath	ospital: 1 Inpatient 2 I	ER/Outpatier 28b. Time o Injury	f 28c. injun Work	er: 4 🗆 Nursing H		ence 6 Other (Specify)	
Division		Certification:	Accident Investigation Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	-		28f. Location (St City or Town		r Rural Route Numbe	ır,
	To the Hospital or within 24 hours afte To the Funeral Dit completely filled in	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the tim vestigation, in my o	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and manne late and place, and	er as stated. due to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licenso	5333	2	2 1 151	fonth, Day, Year)	
			30. Name and address of person who con THOMAS G. JOHNSON,			Print) FOURTH S	T. OAKL	AND, MAR	YLAND 215	550	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 8 200	32. egistrar's Signar	ture	Contract of the second					

	Registrar			Cer	tificate	of Deat	h	F	eg. No	105	07513
hysician								2. Date of Dea Month	th Day	Year	3. Time of Death
/Medical				ipinet				Februar			11:40 a ^M
Examiner				,	-				4c. Cou		
								8 Date of Birth			
	222-16-0082	1⊠M 2□F	76	Yrs.				(Month, Day	, Year)		
_	Usual Residence of Decedent								,		224,1416
how	10a. State 10b. County		10c. City, T	own or Loc	alion						10d. Inside City Limits
Ba-f-		cil					ngo				1 ☐ Yes 2 🔀 No
Dire					10f. Zip Co		_		l0g. Citizen		•
a 23,				12 W	Vas Dasadas		-	posity Voc or No.	14.5		
Fun		Armed Fo	orces?	lf.	Yes, specify	Cuban, Mexic	can, Puerto	Rican, etc.)	E		
by I	3 Widowed 4 Divorced	If Yes, Gi	ve	1	☐ Yes 22	No Speci	ify:		Spe	cify:	White
natur local			1	6a. Deced	ent's Usual (Occupation	act of work	rina			
" uer	Elementary/Secondary (0-12)	7	1-4or 5+)	lite. C	OO NOT use	retired)	031 01 11011	arry		•	. ,
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traur											
tam 2 other	20a. Method of Disposition	,				S					
y or c			State				027	26/05			
ortan injur e			, nese	22	Name and	Address of Fa	cility	-			-
d y a	Shower h	Farran.	a Sc.								P.A.
3.1	23a. Part1. Enter the disease, or	complications that	caused the death. I								Approximate
sician	Immediate Cause (Final	only one cause on t	11.0	Δ							Interval Between Onset and Death
	resulting in death)	aDue to				_					
niner	One was the line and dilinear	h	PNEUMO	NIA							
ner ner	if any, leading to immediate cause. Enter Underlying		(or as a consequen	ice of):	8400000		-5 -575	5.5			
trans	that initiated events	c			o Be	DEME	BNTI	A			
urial Ey	resulting in death) cast	Due to	(or as a consequen	ice of);							
dica		d									
Se as	IF FEMALE:	23c. If yes, ou	tcome of pregnancy	,					234	Date of deliv	(ADV
foru	in the past 12 months?									Month	Day Year
December 1997 (all produced from the produced fr											
Decelerate Names Press, Macton Later Dance Page 10 Dance	the cause of death?										
a pa								1 □ Y	es 2 🗆 No	o 3□Pro	bably 4 Unknown
plet										b. Were aut	opsy findings available
om com								perfor	med?	death?	
stor, p	25. Was case referred to medical					26. Pl	ace of Dea				
direc		Hospital: 1	Inpatient 2 ER	/Outpatien	3 □ DOA	Other: 4	Nursing H	ome 5 🔀 Resid	ence 6 🗆	Other (Speci	fy)
neral			of Injury 28 oth, Day Year)		280	. Injury at Work?		28d. Describe h	ow injury oc	curred	
the fu	2 Accident investig	galion			М	1 ☐ Yes 2	□No				
rtifi	dotom	ined 286. Place	e of Injury - At home ling, etc. <i>(Specify)</i>	e, farm, stre	eet, factory, o	office				ımber or Rur	al Route Number,
Ce	20-0-45	Division Tall	free to the t				ss				N GOTO LEE
Hica	(Check only 2 Medical	Examiner: On the b	pasis of examination	iage, death n and/or inv	estigation, ir	the time, date i my opinion, d	and place, death occur	red at the time,	ause(s) and late and plac	manner as s ce, and due t	stated. to the cause(s)
o the			mor stated.		29c. l	License numb	ər		29d. Date sid	gned (Month,	Day, Year)
r ŏ	1	M Dun	ms						•		
/	30. Name and address of person	who completed care	se of death (Item 2)	3a) (Type		00011	- 1		C1541	KY,	
2						TUN, M	0,2	1691			
								-			
State	31. Date filed (Mortili, Day, Year)	02.1									

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of	Maryland		artment of F rtificate of		Mental Hy	giene Reg. No:	05	07514
	Physici		1. Decedent's Name (First, Middle, I	•					2. Date of D Month Februa		2005	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, g		per)		4b. City, Town, o	r Location of Dea		3	nty of Death	
			Doctor's Commun				Lanham	1 ((1)				orge's
	Funeral Director		5. Social Security Number 6 217-46-9335	.Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	irth lay, Year) 1, 1945		plece (State or Foreign ntry) nington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation	-				10d. Inside City Limits
	Maryl f sho	jo	MD Prince	George's	Lanh							1X Yes 2 □ No
	r 28a	irec	10e. Street and Number	dedige 3	папп	iani -	10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	th with	a D	7302 Good Luck	Road			20706			US.	A	
	er dea	Funeral Director	11. Marital Status	12. Was Decedo Armed Forc	es?		Was Decedent of H f Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or N rto Rican, etc.)		ace - Ameri	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 X No	Specify:		Spec	whit	
215-0036	within 72 hours after death with the Marylend ane. than "naturel", or Items 23e or 28e-f show the Medical Everther that the rectified at	ted t	15. Decedent's	Education		16a. Deced	dent's Usual Occup	ation		16b. Kind of	Business/Ir	ndustry
215	hin 72	ple	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4		(Give life. i	kind of work done DO NOT use retired	during most of wo d)	orking			,
2	filed wil Hygien other th	Completed		4		Comme	ercial Ad				Food	
Maryland	be fill ntal H od ott	Be	17. Father's Name (First, Middle, La	st)					me (First, Middl		ame)	
ž	should nd Men marke umatic	은	Harold E. Long 19a. Informant's Name/Relationship	(Type Print)		19h Mailir	ng Address (Street		F. Del		m State 7i	n Codel
Ma	and 2 s ealth an n 27 ls		Beatrice Sager,				Good Luc					
ē,	Is 1 as		20a. Method of Disposition		20b. Pla		sition (Name of natory or other place		Date	20c. Location		
E	Pages nent of ant: If It		1 X Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe		ale			ı	. 22,2005	Brent	wood,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "naturel", or Itams 23s or 28s-7 show any injury or other traumatic event, the Medical Eventinet must be notified at once.		21. Signature of Funeral Service Lice	ensee //		22	2. Name and Addre	ss of Facilit Gas	sch's Fu	neral H	lome,	P.A.
-	205 3		-deut	1 Hay	/		739 Balti				le, M	
			23a. Part1. Effect the disease, or shock, in heart failure. List on	ly one cause on sac	ch line.					arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a//	Acute	Myou	andial.	Ir forme.	pm-			1hr
	Examiner			Due to (or	Diahut	ince (T):	rendral.	10				
		Jer	Sequentially list conditions, if any, leading to immediate		as a conseque							(
	cuted nd ransit	Examiner	cause. Enter Underlying that initiated events	C								
30,	oe exe	EX	resulting in death) Last	Due to (or	as a conseque	nce of):						
68760,	icate be executed physician and s the burial-transit	edical		d								
Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnanc	су				23d. I	Date of deliv	rerv
	death e atter	Physician/M	in the past 12 months?	4 Pregnar	h 2□Fetald nt at time of dea		Ectopic pregnancy Other (specify) _	<u></u>			Month	Day Year
P.0	at the by the	hys	9 □ Unknown	9□ Unknow								
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant conditions	contributing to dea	th but not result	ing in the u	nderlying cause giv	en in Part I.				the cause of death? bably 4 Unknown
Soro	w requir been si should I	eted							-			
Records,	The law cate has page 2 t	Completed							per	formed?	death?	opsy findings available ompletion of cause of
Vital	-	a)	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath (Check only		1 🗆 Yes	2 No
<u></u>	Physicien: this certification, ral director,	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Ing	oatient 2 E	R/Outpatier	it 3□ DOA Oth	er: 4 🗆 Nursing			Other (Speci	fy)
n of	ding Physicien: h. After this certific funeral director,		27. Manner of Death 1 Avatural 5 Pending	28a. Date of (Month,	Injury 2 Day Year) 2	8b. Time of Injury	28c. Injur Wor	y at k?		how injury occ		
Sio	r Attending er death. rector: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	he	6 taines - 04 ham			Yes 2 □ No	29f Langting	(Ctract and him	mhar ar Du	al Route Number,
Division	after all or A	Certification:	4 ☐ Homicide determine	200. Place 0	, etc. (Specify)	e, rarm, str	eet, factory, offica		City or T	own, State)	mber or Aur	ar noute Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical C		Physician: To the b aminer: On the bas and manne	is of examinatio							
	o the	Mec	29b. Signature and title of certifier	and maine	stated.		29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)
)			> puchal (Served.	nes)		D	2628	7	2/1	5/05	-
2	(5)		30. Name and address of person when 7305 BA/thm		of death (Item 2	23a) (Type,				20740		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 2 200		gistrar's Signatu	re	et i			.•		
	riegisti	e.II	1 LD ~ ~ 200			1						

		1	1 - State of Maryland / Registrar		artment of H tificate of L			iene	05	07515
	Dharaisia		Decedent's Name (First, Middle, Last)				2. Date of Deat Month Februar		⊃X 0 A/⊏	3. Time of Death
	Physicia /Medic	al	Betty Grace Lawrence				Februar		2005	1:00 A. M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Aberde	Location of Death		Harf	y of Death	
	E		801 Chelsea Road 5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birtho	place (State or Foreign
	Funeral Director		215-42-8237 1 M 2 XF 74	Yrs.	Months Days	Hours Min.	7/31/30	Year)	New	Mexico
	D .		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	cation					0d. Inside City Limits
	Aaryla F sho	ō	MD Harford Aberd							1 ☐ Yes 2 🛣 No
	the N	Directo	10e. Street and Number	10011	10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
	h with		801 Chelsea Road		2100	1	i	U.S.	Α.	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H f Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americack, White,	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		1 ☐ Yes 2 ☑ No	Specify:		Speci		
21215-0036	hour	ed b		Sa. Dece	dent's Usual Occup	ation		16b. Kind of E		
215	nin 72	plet	(Specify only highest grade completed)	(Give life.	kind of work done on DO NOT use retired	turing most of work ()	king			
21	od with	Completed	Unknown 0	Home	emaker			In hor		
Baltimore, Maryland	d be filted hy	Be	17. Father's Name (First, Middle, Last) Ralph Newsom			18. Mother's Nam Ruth	e (First, Middle, I Unknown	Maiden Suma	me)	
Ž	should nd Me mark matic	ဥ		9b. Mailir	ng Address (Street	and Number or Rui	ral Route Number	, City or Towr	n, State, Zip	Code)
Ma	alth ar 27 is or trau		Bobbi Caudill (Daughter)	42	228 Webst	er Road,	Havre de	e Grace	e, MD	21078
ore,	of He of He fitem r othe	1	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place ceme	of Dispo	sition (Name of matory or other place	e)		20c. Location		
ij	Pag ment tant: h		'4 Donation 5 Other (Specify)	utia	Cemetery	3/3/	/05 .	Perryma	an, M	aryland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinat must be notified at ODEs.		21. Signature of Funeral Service Licensee		2. Name and Addre Farring-C Aberdeen,	argo Fune Maryland	eral Homo	e, P.A -3399	•	
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause any ach line.	o not en	er the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Prysician		Immediate Cause (Final disease or condition resulting in death)	MI	4.					
Н	/Medical Examiner		Du to or as a consequence	ce of):	1					
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	ce of):						-
1	id ansit	Examiner	cause. Enter Underlyin. Cause (Disease or injury that initiated events c.	1510	h					
0,7	e exection and and and and and and and and and an	EX	resulting in death) Last Due to (or its a consequence	ce of):	hit.	10				
8760,	icate be executed physician and s the burial-transit	dlca	d. UM JOB HVE	VIETY	m imu	IVC				
9 X	eath certific attending p	/Me	IFFEMALE: 23c. If yes, outcome of pregnant			4.	r	23d. D	ate of deliv	erv
Box	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death		⊒Ectopic pregnancy ☐ Other (s <i>pecify)</i>			N	Month	Day Year
P.0	that the de led by the a detached t	hys	9 ☐ Unknown 9☐ Unknown				00- Dida		-4-"	
	000		Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause giv	en la Part I.		es 2□No	ntnbute to	the cause of death?
Ö	w requir been si should I	eted	THE PROPERTY OF THE PROPERTY O	140	VI OUTILITY.		24a. Was a			
Vital Records,	has has	Completed by					' autop	med? 2 No	death?	opsy findings available ompletion of cause of
tai			25. Was case referred / medical			26. Place of Dea	th (Check only of		1 🗆 Yes	2 100
Į Š	S S	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	/Outpatie	nt 3 DOA Oth	00	ome 5 esid		ther (Spec	fy)
n of			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28t (Month, Day Year)	b. Time o	Wor		28d. Describe h	ow injury occ	urred	
sio	at at	catl	2 Accident investigation	4		Yes 2 □No	29f Location /6	Yraat and Nus	nhar or Pu	ral Route Number,
Division	or Attendation of after death	Certification:	4 Homicide	, tarm, st	reet, tactory, office		City or Tow	n, State)	nber or Hur	ai noute Number,
	Hospite 4 hours Funeral tely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowler 2 Medical Examiner: On the basis of examination and manner stated.							
	To the within 2 To the comple	Mec	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	e number	:	29d. Dat sign	ned (Month	, Day, Year)
			My Sup Sim M.D.		D4	641		3/1	17	
	13		30. Name and address of person who completed cause of death (Item 23	111	· / /	VID!	mn	110	TP	
	Sta	-	11. Inte filed (Minth, Day, gar) 32. The r's Signature		in Im	1110	2117	-10	10	
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		1 - For Stete Registrar	State of M	aryland /		artment tificate				F	Reg. No.2 ()	05	075	116
	ician dical	Thomas	Andrew]	Larsen			F	Date of Dea Month ebruar	y 12,		3. Time of 1	
Exar Funer	niner	4a. Facility Name (If not institution 26374 Mt. Vern 5. Social Security Number	on Road 6. Sex 7. As	ge (In yrs. last b	irthday)	4b. City, To Prince If Under 1 Months	cess Year I			. Date of Birtl	Som	erset	place (State or	Foreign
Direct	or	160-14-6226 Usual Residence of Decedent 10a. State 10b. County		84		cation		Tiours	J	fuly 9,		Penn	sylvan: 10d. Inside Cit	ia y Limits
politimity in the plant of the control of the control of the market beauth with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any Injury or other treaments event, the Medical Examinar master contined at any Injury or other treaments.		11. Marital Status 1 Never Married 2 Marital Status 15. Deceden (Specify only higher Specify only higher Status Specify Secondary (0-12) 12 17. Father's Name (First, Middle, Landerica Marital Status Specific Status Specific Status Specific	12. Was Decedent Agned Forces: 1	Ever in U.S. No WWII 16 5+) 18 26 20b. Place cement	a. Decec (Give life. Vi 9b. Mailir 6374 of Disposory, cres bur	dent's Usual kind of work DO NOT use Ce Pri	2185 nt of Hisp ry Cuban, No Occupatic done dur oretired) Incip Street and Perno e of ner place) nator Address Fune	onic Origi Mexican, Specify: on origing most of the second secon	of working 's Name (e Nil r or Rural ad, F Dai)2/15	fy Yes or No-can, etc.) First, Middle, Kalaise Route Number Princes te /2005	Educa Maiden Suma en or, City or Town as Anne 20c. Location	tice - Ameriack, White,	can Indian, etc. te ndustry Code) 21853 own, State Marylan	nd
(ale be executed The physician and the burial-transit	al er lcal Examiner		b. Due to (or as		e of):	er the mode	of dying,	such as c	ardiac or	respiratory ar	ess Ani	ne, M	D 21853 Approximate Interval Betwo Onset and D	veen
is, F.C. BOX 601 res that the death certificate igned by the attending phys be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		e of pregnancy 2 □ Fetal dea at time of death		□Ectopic pre □ Other (spe						ate of delivitonth	•	'ear
requir requir bould	eted by	Part II. Other significant conditi	ons contributing to death	but not resulting	in the u	nderlying ca	use given	in Part I.		1 🗆 V	res 2 No an 24b	3 Pro	the cause of debably 4 UU opsy findings a completion of ca	Inknown
VISIOII OI VIIAI NEC Attanding Physicien: The law r death. ector: Alter this certificate has b by the funeral director, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpat 28a. Date of Inj (Month, Di gation		Outpatier Time o Injury		Other: Bc. Injury a Work?	4 □ Nur	rsing Home	1 ☐ Yes Check only o	2/2140	1 ☐ Yes	2 No	
To the Hospital or Attanding Pr within 24 hours after death. To the Funeral Director: After th completely illied in by the stuneral	cal Certific)	ng Physicien: To the bes	tc. (Specify) t of my knowled	ge, deat	h occurred a	it the time		d place, ar	City or Ton	vn, State) cause(s) and r	manner as		
To the Hy within 24 To the Ft	Medical	(Check only 2 Medical one) 29b. Signature and title of certifie	Examiner: On the basis and manners	tated		-					-			F
	State istrar	30. Name and address of person 30 / 3 / Mon. 31. Date filed (Month, Day, Year, FLB	+ Vernm	RU trar's Signature	л, (туре,	Priv	ices.	SA	Ann	e 1	11	718	53	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** FEB 12:40AM OLIVER MYGRS 16 DAUND 8005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept. 3,1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours **№** M 2□F 236-20-7520 West Virginia Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Items 23a or 28a-f show 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Charles Funeral Directo Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Prospect Avenue 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Y Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othen sny injury or other traumatic event David Dale Myers Goldie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Myers wife 8 Prospect Ave., Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Park Hill Cemetery Feb. 19, 2005 Marbury, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility.
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 Part1. Enter the dis shock, or heart fail ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Imnal **Physician** disease or condition resulting in death) meurnon days /Medical Due to (or as a consequence of): Examiner Dente Sequentially list conditions, if any, leading to immediate cause. First cause or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Matz Chaise P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 2 1 No 1 Tyes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Thpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 No Certification: To after death. Director: After this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 41854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) strar's Signature State Registrar

	•	For State Registrar	State of Maryland / Dep	artment of Health and I ertificate of Death	Mental Hygiene Reg. No.	2005 075
Physici		1. Decedent's Name (First, Middle, Last)	. MAIZEL		2. Date of Death Month Day FEBRUARY	4, 2005 8:18P M
/Medic Examir		4a. Facility Name (If not institution, give s CASEY HOUSE	street and number)	4b. City, Town, or Location of Death ROCKVILLE		County of Death ONTGOMERY
Funeral Director		210-30-0230	7. Age (In yrs. last birthday N 21 YF 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 12, 1	9. Birthplace (State or Foreign Country) PENNSYLVANIA
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOME	10c. City, Town or L	ocation SPRING		10d. Inside City Limits 1√ Yes 2 □ No
with the 3e or 28	i Dire	10e. Street and Number 14510 HOMECREST D	ORIVE APT. 1010	10f. Zip Code 20906		zen of What Country? D STATES OF AMERIO
within 72 hours after death with the Maryland piene "naturel", or Items 23e or 28a-f show trhen "naturel", or Items 23e or 28a-f show the Modical Examinative traffic during	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
within ene. then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) (Giv life.	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) OSMETICIAN	rking	nd of Business/Industry COSMETICS
al Hyg othe	To Be C	17. Father's Name (First, Middle, Last) ALEXANDER BURA	AK.		ne (First, Middle, Maiden NASCERTAINAB	
1 and 2 s Health ar em 27 ls	-	19a. Informant's Name/Relationship (Ty NANETTE J. SPITZER 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	R - DAUGHTER 6 20b. Place of Disposer cemetery, cro	ematory or other place)	PT. 731 OWI	NGS MILLS, MD 211 cation - City or Town, State
permit. Pages Department of Importent: If it any injury or o		'4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	JUDEAN D	MEMORIAL GARDENS (ANZANSKY GOLDBERG 170 ROCKVILLE PIK	MEMORIAL CH	APEL, INC.
/Medical Examiner physician and physician and physician and the prijal-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ADVANCED BRONCHOG Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d	ENIC CARCINOMA		
The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that I d be deta	by		ntributing to death but not resulting in the EBROVASCULAR ACCIDE		23e. Did tobacco u 1 ☐ Yes 2	use contribute to the cause of death?
	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
g Physicien: Th ler this certificate heral director, pag	n: To Be	27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing F	ath (Check only one) Home 5 Residence 28d. Describe how injur	6 XOther (Specify) HOSPICE by occurred
ttendin death. stor: Afi	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, s)
To the Hospitel or At within 24 hours after d to the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)	rsician: To the best of my knowledge, de- tiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. If place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	Me	29c. License number 1 4 1 2 1 8	29d. Da	te signed (Month, Day, Year)
112		30. Name and address of person who con CHARLES HARRISON	ompleted cause of death (Item 23a) (Type, MD 6001 MUNCA	e, Print) STER MILL RD. ROC	KVILLE, MD 2	20852
St Regist	ate	31. Date filed (Month, Day, Year) FFR 1 8 200	3 Agistrar's Signature	marke		

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:35 PM 05 16 HARDIN MASSEY DOROTHY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🛣 F 85 INDIÁNA Director 316-18-9413 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND WORCESTER OCEAN PINES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 909 YACHT CLUB DRIVE USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MACY ALVIN HARDIN MABEL **JAMES** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 YACHT CLUB DRIVE, OCEAN PINES, MARYLAND 21811 ROBERT G. MASSEY/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō 4 Donation 5 Other (Specify) ARLINGTON NATIONAL CEM 3/2/05 ARLINGTON, VIRGINIA inlury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kolunt WA HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death iton. 3 0245 Physician disease or condition resulting in death) /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner use as the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, nutcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 🗆 No 2 9 No 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Hippatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar

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"natural", or Items 23a or 28a-f show

al Hygiene.

and Mental Mental 90

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is

To the Hospital or Attending Physician: The law requires that the death certificate be executed

after death.

within 24 hours a To the Funeral C

1 and 2 should

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division of Vital Records,

FEB 2 2 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Clara Marie Mainster February 17, 2005 0500 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2√2 F 214-12-9455 Director 83 Feb 8, 1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show other treumatic event, the Medical Examinar must be notified at Hampstead 1 ☐ Yes 2 ₩ No Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 4511 Mt. Carmel Road 21074 or Items 23a USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 🔀 No f Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Ā Specify: white 3 ₩ Widowed 4 Divorced Year or Dates nit. Pages 1 and 2 should be filled within 72 hours arment of Health and Manlal Hyggien. ordent: if then 21 is marked other then "ratural, injury or other treumatic event, the Medical Examinjury or other treumatic events. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clara Louisa Rolfe John E. Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Warehime, daughter 4511 Mt. Carmel Road, Hampstead, MD 21074 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury of once. 02/18/2005 Carroll Cremations Hampstead, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00723 Eline Funeral Home Mul 934 South Main St, Hampstead, MD 21074 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1515 /Medical Due to (ol as a consequence of): **Examiner** Nummia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physicien Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year jo 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown . Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 2 No ours after death.

Nerel Director: After this certifical filled in by the funeral director, it or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number mo 3318 WIL 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN BUSINESS CTR. DR. REISTERSTOWN, MD 21136 KUSHNER 114 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	For State Registrar	State of M	aryland / Depa	artment of H			giene 0 0	5 07522
Physician	1/13 0 0 0 0 0 0 0 1		2400			2. Date of Dea Month	Day Y	ear 2:16 AM
/Medical Examiner				4b. City, Town, or	Location of Death	tebruca	4c. County of	
Examine:	Kline Hospica	z House		Mount			Fred	erick
Funeral Director	5. Social Security Number 212–28–6420	6. Sex 7. Ag 1 ⊠XM 2 ☐ F	ge (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 26,	Year) 9 1921	Birthplace (State or Foreign Country) Italy
land	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or Lo	ocation				10d. Inside City Limits
Many B-f sh	Maryland Frede	rick	New Ma	rket				1 ☐ Yes 21 No
with the Ma or 28a-f s be notified	10e. Street and Number			10f. Zip Code 21774		1	log. Citizen of Wha	at Country?
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ING Z1Z13-UU3D be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be maiffied at Be Completed by Funeral Director	3 Widowed 4 Divorce	ried 1 Tes 24	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2⊠ No	Specify:	Rican, etc.)	Black,	White, etc. White
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S, F. es that t gned by be detait by Ph		ons contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
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The la						24a. Was a autops perfor	sy pric med? dea	ore autopsy findings available or to completion of cause of ath? Yes 2 \(\) No
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UIVISION C spitel or Attending P ours after death. Neral Director: After t filled in by the funera	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Place of in	jury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
DIVISIO To the Hospitel or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the it	29a. Certifier Certifyi (Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or in	h occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the c rred at the time, o	ause(s) and mann late and place, and	ner as stated. d due to the cause(s)
To the comp	29b. Signature and title of certific			29c. Licenso	· C· ·		29d. Date signed (1	05
9	30. Name and address of person	who completed cause of a		Print) Tou	e House	Ave,	Redere	el. MD
State Registrar	P 16-10/ J.	7 200E 32 Registr	rar's Signature	-4				

State of Maryland / Department of Health and Mental Hygiene 07523 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** February 16 2005 Shirley Bishop Mover 6:55 AM /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours Yrs. Michigan 230-26-7896 78 Jan. 7, 1927 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinatina Le notified an agines. 1 XYes 2 No Wicomico Salisbury Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 900 Booth St. 21801 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 ☑ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harold T. Bishop Mary Mumford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Willoughby sister 5432 White Hall Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Odd Fellows Cemetery 2/21/05 Burlington, NJ * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee Brink. But 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner S juentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 21 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Donknown 1 ☐ Yes 2 ☐ No PEMENTIA STEOPOROSIS 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of oduse of death? certificate has burnector, page 2 s 1 Yes 212 No Be 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) director Other: 4 V ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident Director: , 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by determined 4 Homicide 1.1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and fittle of certifier 16/05 120060315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Easternshore Dr. Salisbury MD 21804 Mahesha Thimmarayappa M.D. 32. Registras Signature 31. Date filed (Month, Day, Year) State FEB 1 7 2005 Moscow Registrar

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	Examir	er	4a. Facility Name (If not institution, give s					r Location of Death		4c. Count	ty of Death	
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	Funeral Director		220-16-9730		(In yrs. /a 31	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 15	,1923	9. Birth Cou	place (State or Foreign ntry) Iaryland
	s within 72 hours after death with the Maryland liene. rithan "natural", or Items 23a or 28s-f show tre Medical Exaministriust be notified at the Medical Exaministriust be notified at)r	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo						10d. Inside City Limits 1 ⊠ Yes 2 □ No
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	tem tem	Funeral		12. Was Decedent Ev Armed Forces?		5. 13.	Was Decedent of h If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ack, White,	can Indian, etc.
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ore	of H of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	206. Pia	metery, crei	osition (Name of matory or other pla	ce)	Date	20c. Location	- City or 1	own, State
Ĕ	Pages ment of I ant: If it ury or o		*4 □ Donation 5 □ Other (Specify)	omova, nom otato	R.A	A. Ferr	is & Co.,Ir	oc. 02/	20/05	West Che	ester,	Pennsylvania
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service License	THEINN	50	1		ss of Facility tterson { e, Maryla				P.A.
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Δ.	The law requires that the death certifical tite has been signed by the attending phyage 2 should be detached for use as the	H.	Part II. Other significant conditions con	tributing to death but	t not resul	Iting in the u	inderlying cause giv	ren in Part I.	23e. Did tob	acco use cor	ntribute to	the cause of death?
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oro	w require been sig should b	etec	CILE		C()U							
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,	3+ IVA			- Carrier	ath (Item	23a) (Type,		1				01076
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	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. A contact than "natural", or Itams 23e or 28e-f show avent, the Medical Exam for most be invitibled at	Funeral	1 Never Married 2 Married	Armed Forces?		If Yes, spec	ify Cuban	spanic Origin? n, Mexican, Pu	? (Specify Yes or N Jerto Rican, etc.)	0- 14. Ra	ice - Americ ack, White,	
	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Tes 2	ONK	Specify:		Spec	ify: B	Lack
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mary land Elely-000	2 sh and Is m raum		19a. Informant's Name/Relationship (7						Rural Route Numb			
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	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If itam 27 is marked any injury or other traumatic a once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dis	position (Nam omatory or ott	ie of her place)	Date	20c. Location	- City or To	wn, State
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-	within To the	Σ	29b. Signature and title of certifier				License r			29d. Date signe	ed (Month, D	Day, Year)
			1/1000	mo		L	2006	7/50		Febru	ary 1	6, 2005
	(1)		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type	, Print)						
e e			Richard	L. Palmer	M.D. 13	28 Sou	ther	n Ave.	, #310, V	Wash T	C 20	032

			1 - For State Registrar		State of	Marylan		artmen rtificate					Reg. No.	00	5	075	526
П	Physic	ian	1. Decedent's Name (F	First, Middle, La		T1 1	м.		1			2. Date of De Month		, 20	ear		of Death
	/Medi	cal	A 5 22 M	4 1-144 41-1 -1	Donald '		re Mis			Location of	of Dooth	Februa		, 20 County of		11:4	5 A.M
	Examir	ner	4a. Facility Name (If no Crofton						fton		or Death			ne A		de1	
	Funeral		5. Social Security Num	ber 6.5	Sex 7		last birthday)	If Under	1 Year	If Under Hours		8. Date of Bir (Month, Da					or Foreign
	Director		282-03-9 Usual Residence of De	scedent	1 X M 2□F	86	Yrs.	Months	Days	Hours	Min.	Apr. 8	, 19		enn	sy1va	nia
	anylar show	_		b. County	1.	10c. Cit	ty, Town or Lo								1	10d. Inside (1 [X Ye	City Limits es 2 □ No
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	death ms 2;	Funerai	11. Marital Status		12. Was Deced	ent Ever in U	.S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)		4. Race -		can Indian,	
21215-0036	iti: Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ritent: If tiem 27 is marked other than "netural", or liems 23a or 28e-f show njury or other treumetic event, the Madical Examinat must be notified at	þ	1 Never Married 3 Widowed 4		1 Armed Ford 1 Ares 2 If Yes, Give Year or Dat	□No		1 ☐ Yes		Specify:		nicari, etc.)	1	Specify:	White,		
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N	filed Hygie other	O I	17. Father's Name (Fire	st, Middle, Last	· · · · · ·		FIOCE	ii emei	16 01			e (First, Middle					
<u>a</u>	ould be f Mental H warked of	To B	Novak N	Miskowi	ch					R	ose	Nagy					
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumetic event, the Me	-	19a. Informant's Name	/Relationship (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	a <i>l Route Numb</i>	er, City or	Town, St	ate, Zip	Code)	
	and 2 salth a n 27 I		Frances Mi	skowich	n - Wife		_					e, Bowi					
ore	of He of He If iten		20a. Method of Disposi		☐Removal from St	ate 20b. F	Place of Dispo cemetery, crea	sition (Nan natory or o	ne of ther plac	θ)		03-05				own, State	
Ë	Pages tment of it tent: If its jury or or		`4 Donation 5 [Other (Special	(y)		lingto			l Cem						rgini	.a
Baltimore,	perrit. Pages 1 and 3 Depertment of Health Importent: If Item 27 any injury or other tra 2005.		21. Signature of Funer	al Service Lice	nsee A	10		2. Name an			De	all Fun					
	202.0	93	23a. Part1. Enter the	tisease or com	nolications that car	sed the deat						Bowi		arvla	and	20715 Approxima	
			shock, or heart fa	illure. List only	one cause on eac	ch line.							,			Interval Be Onset and	etween
	Physician /Medical		disease or condition resulting in death)		a lery	nina	L Ad	eno(cur	cino	ma (of Aba	1cm	ner	4	ma	its
	Examiner				M.o.	tare +	ertic	C	NA C	ine	omo	NI	114	10		mo	uthy
	_ = #:	Je.	Gaquentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju- that initiated events	diate		as a conseq						-	LV			,	
	be executed sicien and burial-transit	Examine	Cause (Disease or injuthat initiated events	iry 1	o	Lest	ina	le	-6	54	14	ctio	22			day	18
Ő,	e exe ien a urial-i	EX	resulting in death) Last	' I	ue to (o	as a conseq	quence of):										1
8760	cate b	dicai			d. =				_						-		
9 xo	ding p	/Med	IF FEMALE:		23c. If yes, outco	me of pregna	ancv							2d Date	of doline		
.O. Bo	The law requires that the death certificate be executed its has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent print the past 12 mo 1 Yes 2 N 9 Unknown	nths?	1 Live birt	h 2 □Feta nt at time of d	aldeath 3	Ectopic pr Other (sp			-		2	3d. Date Month		Day	Year
σ.	res that the igned by be detacted		Part II. Other significa	nt conditions	contributing to dea	th but not res	ulting in the u	nderlying c	ause give	n in Part I		23e. Did t	obacco u	e contrib	ute to th	he cause of	death?
Records,	uires sign	d by										10	Yes 25	№ 3	☐ Prob	ably 4	Unknown
200	w requ	Completed										24a. Was	an	24b. We	re auto	psy findings	s available
Re	The lav	шс											rmed?	dea	ath?	mpletion of 2□ No	cause of
		Φ	25. Was case referred	to medical						26. Place	of Deatl	1 ☐ Yes	2 ZNo	1	1168	2U NO	
<u> </u>	g .s .g	To B	examiner?		Hospital: 1 🗆 Inp	patient 2	ER/Outpatie	nt 3 DC	Othe	/		me 5 Resi		Other	(Specif	y)	
		1 1	27. Manner of Death	5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	2	8c. Injury Work			28d. Describe	how injury	occurred	í		
Division	Attending r death. actor: After oy the fune	Certification:	2 Accident	investigatio				М		∕es 2□	-						
É	2 8 5 2	rtiff	4 Homicide	determined	20e. Place o	f Injury - At h g, etc. <i>(Specif</i>	ome, farm, st fy)	eet, factory	, office			28f. Location (. City or To		i Number	or Rura	u Houte Nui	m <i>ber</i> ,
J	To the Hospital of within 24 hours at To the Funeret D completely filled in	edicai Ce	(Check only 2		hysician: To the base	is of examina											(s)
	ithin 2 the or t	Med	one) 29b. Signature and tells	of certifier	and manne	stated.		290	: License	number	_		29d. Date	signed (Month,	Day, Year)	
i	o T is			101	nello	201	MI)	D	20	10	2	2	1211	0		
6	1111	1	30. Name and address	of person who	completed cause	of death (Item	n 23a) (Type.	Print)				3		1 1	-		
19	1 Wa		Rakesh Aro						wie,	Mar	ylano	20715					
	Sta	_	31. Date filed (Month,		Reg	gistrar's Signa	ature	ونج									
	Registi	ar	FEB	2 2 200	IJ JULI		1										

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H				0 = 0 = 0 = 0
	Physic /Medi		Decedent's Name (First, Middle, Las John William Nev	in, Sr.				2. Date of Death Month February	Day Year 14, 2005	3. Time of Death /
	Exami	ner	4a. Facility Name (If not institution, give 1503 Cedar Park R. 5. Social Security Number 6. Security Number	oad ex 7. Age	(In yrs. last birthday)	4b. City, Town, o	Annapol If Under 24 Hrs. Hours Min.	S Pate of Righ	4c. County of Death Anne Ai 9. Birth	rundel
	Director		Usual Residence of Decedent 10a. State 10b. County		80 Yrs. 10c. City, Town or Lo		Hours Min.	Sept. 16,	1924 Mai	ryland 10d. Inside City Limits
	with the Ma a or 28a-f be notified	Directo	Maryland Anne Ar 10e. Street and Number 1503 Cedar Park			10f. Zip Code	polis	10g	. Citizen of What Cou	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exertifier must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1			21401 lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- D Rican, etc.)	U.S.A. 14. Race - Ameri Black, White, Specify:	can Indian,
Maryland 21215-0036	led within 72 hi ygiene. her than "natu it, the Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+	(Give life. L	OO NOT use retired	during most of world a) ent Opera	tor	b. Kind of Business/In	
ryland	hould be filled Mental H markad ott matic even	To Be	17. Father's Name (First, Middle, Last) Robert Nevin, Sr. 19a. Informant's Name/Relationship (T)		10h Maille	Address (Course	Mary A	e (First, Middle, Ma.	ahy	
re, Ma	tand 2 s Health an tam 27 is other trau		Dorothy M. Nevin/ 20a. Method of Disposition		1503	Cedar Pai	ck Road	Annapolis	ity or Town, State, Zip Maryland c. Location - City or To	21401
Baltimore,	permit. Pages Department of Important: If is any injury or once.		LXDBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funer I Service Licens	0	Maryland 22	vets. Cen	netery 2/	22/2005 hn M. Tay	Crownsvill lor Funera nnapolis,	e, MD 1 Home
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishook, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	End Stag	ne death. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	certificate be executed ding physician and tse as the burial-transit	dical Examiner	if any, leadin; to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	consequence of):					
C. Box 6	death e atter id for u	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of delive Month	ery Day Year
Records, P	w requires that the been signed by th should be detache	ted by P	Part II. Other significant conditions cor	ntributing to death but	not resulting in the un	derlying cause give	en in Part I.		co use contribute to th	
_	The law ate has b page 2 si	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of
5		0 0	examiner?	lospital:	2 ER/Outpatient	3 DOA Othe		(Check only one)	. 50	- NO
	After After	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y		28c. Injury Work	4 LI Nursing No	28d. Describe how in	e 6 □Other (Specify njury occurred)
DIVISION	To the Hospital or Attendential or Attendential 24 hours after death To the Funeral Diractor: completely filled in by the the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	et, factory, office		28f. Location (Street City or Town, St	t and Number or Rural late)	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one)	sician: To the best of rener: On the basis of exand manner stated	camination and/or inve	estigation, in my op	inion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To CO		29b. Signature and title of certifier	am			55035		Date signed (Month, L bruary 15,	- '
			30. Name and address of person who co Lynn Hallarmen, I	MD 3900 L	och Raven	rint) Boulevard	d Baltim	ore, MD 2	1218	
	Stat Registra		31. Date filed (Month, Day, Year) FEB 17 2	005 32. Projetrar's	Signature	mach 1				

07528

		•	1- State Amend Item 1 Registrar	7&19a per fh (3841 3-	tificate	tas of Death	Reg	. No.	01020
	Physicia	an	Decedent's Name (First, Middle, La: Earl Fr	st) anklin	Nokes			2. Date of Death Month February	Day Year 2005	3. Time of Death 8:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give		NORCE		wn, or Location of Death	represent	4c. County of Deat	
			College View C				derick		Freder	
	Funeral Director			7. Age (In yrs	. last birthday) Yrs.	Months C	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y	^{9. Birt} 1915 Mar	hplace (State or Foreign untry) yland
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Ba-fs	ctor	Maryland Frederi	ck	Freder	ick				XXYes 2 ☐ No
	with th	Directo	10e. Street and Number			10f. Zip Ce	ode	100	g. Citizen of What Co USA	untry?
	ns 23	Funeral	College View Cen 11. Marital Status	12. Was Decedent Ever in t	J.S. 13. ¹		701 It of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
20	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Itam Medical Exerting Invest be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 2 ☐		Rican, etc.)	Specify:	e, etc. White
2-0030	72 hour 'natural	eted t	15. Decedent's E. (Specify only highest gra	ducation	(Give	dent's Usual (done during most of work	sing 16	b. Kind of Business/	Industry
717	d within giene. ar than	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		rakema	n/Conductor		Railroa	d
yland	d be file	Be	17. Father's Name (First, Middle, Last, Edgar	Harry Henry	Nokes			e (First, Middle, Ma Almire Fo		
Z	should nd Me s mark umatio	2	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (S	Street and Number or Rui			Zip Code)
Ž,	and 2 salth a n 27 is		Carole Hays Carole Hays	nter	1509	3 Germa	anna Highway	y, Culpep	per, VA	22701
baltimore	Pages 1 and of He and: If Itan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	Place of Dispo cemetery, creat 1peppe:	sition (Name matory or othe	of er place)	Date 20	Culpeppe	Town, State
Saltil	permit. Pages Department of Important: If I any injury or one		21. Signature of Fureral Service Lice	··	22	2. Name and	Address of Facility F	ound and	Son Funera	1 Home
_	20E # 9		to lift	plications that caused the dea			rryville Pil			Approximate
	Physician	3,000	Immediate Cause (Final disease or condition	one cause on each tine.	OUE	er the mode t	or dying, such as caldiac	or respiratory arres	t,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	>				10 425
L	pe sit	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
•	and and al-trans	Examiner	that initiated events resulting in death) Last	cDue to (or as a conse	quence of):					
08/00	tificate be executed ig physician and as the burial-transit	cal	(d						
	ertifica ling ph e as th	Medi	IF FEMALE:							
7. BOX	requires that the death cert neen signed by the attendin hould be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of preging the limit of	tal death 3	∃Ectopic preg ∃ Other <i>(spec</i>			23d. Date of def Month	ivery Day Year
ı.	that the		9 Unknown Part II. Dther significant conditions		sulting in the u	ınderlying cau	se given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ras,	w requires that s been signed to should be deta	ed by						1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Hecords	aw as b	Completed						24a. Was an autopsy performe	prior to	stopsy findings available comptetion of cause of
	ate pa							1 ☐ Yes 2	No 1 ☐ Yes	2 2 N o
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2[⊒ ER/Outpatie	nt 3 DOA	Othor	th <i>(Check only o⊓e)</i> ome 5 □ Besiden	ce 6 ☐Other (Spe	city)
ō	ding Phys h. After this funeral di	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		: Injury at Work?	28d. Describe how		City
	endin sath. or: Aft he fun	atio	1 Accident 5 Pending 2 Accident investigation	n	tnjury	М	1 ☐ Yes 2 ☐ No			
DIVISION	al or Att s after de il Diracte id in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, st cify)	reet, factory, o	office	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	Medical C		mysician: To the best of my ki miner: On the basis of examin and manner stated.						
	within 3	Me	29b. Signature and title of certifier			29c. I	icense number	290	d. Date signed (Mont	h, Day, Year)
			• 4	MI		1	-31912		2/18/	05
			30. Name and address of person who	completed cause of death (Ite	P055U W	Print)	pine, Fr	4) E(21) C4	mD 21	702
	Sta	ite	31. Date filed (Month, Day, Year)	2005 32. Registrar's Sign		focall s				

DHMH 17 Rev 1/2001

death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

the

this certificate

After

within 24 hours e To the Funerei

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per Dr. C843.05/23/05dhb
State of Maryland / Department of Health and Mental Hygiene

•	В		For State of Mar 1- State Amended item #1 2/24/	ýland / Department of Health and N 05 wch@httificate of Death	Mental Hygien Rag. N	2000 075311
	Physici		1. Decedent's Name (First, Middle, Last)	RT Robert Osborne	2. Date of Death	ay 2 Year 0640.A M
	/Medic Examin Funeral Director		4a. Fecility Name (If not institution, give street and number) OASTAL HOSPICE AT 7 5. Social Security Number 220 26 8306 1 AM 2 F	4b. City, Town, or Location of Death ALIS BUE ALIS BUE If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	1 4	Wicomico
	D.	_	Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Location	Sunz , 1	10d. Inside City Limits 1 □ Yes 2 X No
	death with the Maryland ms 23e or 28e-f show from the notified at	Director	10e. Street and Number	Fruilland 101. Zip Code 2/826	10g. C	Citizen of What Country?
36	72 hours after death v natural, or items 23c	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evernment Forces? 1 Never Married 2 Married	er in U.S. 13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: 6 / AC. K
1215-0036	within 72 hourene. Then "neturelle Modical E	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Ja. Decedent's Usual Occupation (Give kind of work done during most of work fife. DO NOT use retired) Sc/F-Empley	king	Kind of Business/Industry
Maryland 21	iould be filed Menta! Hygi harked other hatic evant, I	To Be Co	17. Father's Name (First, Middle, Last) 1064 056010E	18. Mother's Nam Mary	(Style	on Sumame) OSborne
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23e or 28e-1 show amy injury or other traumatic event, it e Mudical Examinal must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Curvilg Hu Lew Dally P. 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	19b. Mailing Address (Street and Number of Ru Str. So. N. 2005. Place of Disposition (Name of competery, crematory or other place)	St-SAL	Coation - City or Town, State
Baltin	permit. Pag Department Important: any injury o		21. Signature Funeral Service Licensee	22. Name and Address of Facility	Bennie si	nith Funeral Home
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition)	tatic Prostate Con		Approximate Interval Between Onset and Death
68760,	ficate be executed g physician and state burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the c			
O. Box	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ecords, P.	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but to	not resulting in the underlying cause given in Part I.	i	o use contribute to the cause of death?
T.	: The law recate has bee	Completed			24a Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Yes
Vita	sician certifi rector	Be.	25. Was case referred to medical examiner?	04	th (Check only one)	0.500
ionoi	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	27. Manner of Death 1 Hatural 5 Pending (Month, Day Y	28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in	
Division	tal or Atters after deal Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, street, factory, office Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	ta Hospital or 24 hours after ta Funeral Diri	Medical		ny knowledge, death occurred at the time, date and place camination and/or investigation, in my opinion, death occu pl.		
	To the within 2 To the complet	M	29b Signature and title of certifie	29c. License number 026278		ate signed (Month, Day, Year) $2 - 17 - 05$
,	1/4		30. Name and address of person who completed cause of deal		il we	21801
Ξ	Sta Registi		31. Date filed (Month, Day, Year) 32. Fegistrar's FEB 2 2 2005	Signature Angel	<i>O</i>)	

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Marylar	nd / Depa	artment of H rtificate of L	ealth and M Death		Reg. No.	005	07532	
П	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of De.		200 [°] 5°	3. Time of Death	
	/Media	cal	ELIZAB			4h Cihi Tourn or	Location of Death	FEB.				_
	Examir	ner	4a. Facility Name (If not institution, give Holy Cross Ho		_	, -	er Spri	nq	40.	County of De MONT	GOMERY	
	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9.8	irthplace (State or Foreign Country)	7
Н	Director		222-07-8789	M 2₹7F 91	Yrs.	Months Days	Hours Min.	Sept.	7,1	913 j	Maryland	
	pu 🔹		Usual Residence of Decedent 10a. State 10b. County	10c Gi	ty, Town or Lo	cation					10d. Inside City Limits	_
	Aaryle 1 sho	ō	MD Montgo			nsingto	n				1 StYes 2 □ No	
	the result	rect	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What (Country?	_
	h with	Funeral Director	4107 Plyers Mi	11 Road		20	895			U.S.	Α.	
	eme	iner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - An Black, Wh	nerican Indian,	_
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2√2 No		,			Black	
2-0036	filed within 72 hours after death with the Maryland Hygiene. othar than "natural", or Iteme 23e or 28e-f show othar, the Medical Examinet mast be rediffed at	ed b	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16b Kir	nd of Busines		
7.	n "na	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most of work	ing	100.11		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
2	d with giene ar tha	mo	6th	College (1-401 54)		Domesti	С			Home		
p		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			Sumame)		
yla	should be filed within 72 hours after death with the Marylan nd Mental Hyglene marked othar than "natural", or Iteme 23e or 28e-f show imetic avant, the Medical Examiner mast be notified at	٦ 2	Phillip Jack					ie Ada			7. 0	_
Maryland 2121	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumetic as the page of the page o		19a. Informant's Name/Relationship (Ty Lester James S		1	ng Address (Street a					DC 20011	
ē,	Heali Heali tam 2		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Date			or Town, State	
Baltimore,	ages on of serior		1 XBurial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	iemovai from State	-	natory`or other plac Heaven	2/17	/05	Sil	ver S	pring,MD	
=	mit. F partm sortar / inju		21. Ignature of Funeral Service Licens								HOME PA	
m	a d iii	-:	- soer	Nince	ee 2.	46 N. Wa	shingto	n St F	Rock	ville	,MD20850	
г			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	h. Do not ent	er the mode of dying	g, such as cardiac	or respiratory as	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	Sepsis							Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
		er	Sequentially list conditions,	Due to for as a consequence	uence of							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			a lune						
á	exection and and rial-tra		resulting in death) Last	Due to (or as a conseq	uence of):							
8760	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dicai		Renal Fai	lure						-	
9	ertifica ling pl	/Med	IF FEMALE:	170 If was subserve of severe								
Box	eath certific attending p	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			2	23d. Date of d Month	lelivery Day Year	
o.	the de	ysic	1 ☐ Yes 2 █No 9 ☐ Unknown	9□Unknown	ibatii J	Guier (specify)		rare				
<u>. </u>	res that the de signed by the a be detached t	by Pr	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco u	se contribute	to the cause of death?	
rds	w requires been sign should be							101	Yes 2[]No 3∏I	Probably 4 Dunknown	
Records,	law re as bee 2 sho	piet						24a. Was		24b. Were	autopsy findings available o completion of cause of	_
	The ate h page	Completed						perfo	rmed? 2 X No	death'	es 2 No	
Vital	Physiclan: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	1		0.1	26. Place of Deat	h (Check only o	ne)			_
of	Physi this c	To	1 Tes 2 XNO	1	ER/Outpatien		4 Unursing Ho	me 5 Resid			pecify)	_
u	ling After une	tion	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	rat (? Yes 2 □ No	28d. Describe i	iow injury	, occanea		
Division	if or Attending Physician: after death. Diractor: After this certific in by the funeral director,	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At h							Rural Route Number,	i
á	al or a safter	Certi	4 Homicide	building, etc. (Specif	(y)			City or Tow	vn, State))		
	To the Hospital or A within 24 hours after To tha Funaral Dirac completely filled in by	edical (sicien: To the best of my kno ner: On the basis of examina and manner stated.								
	To the within To the Comp	Me	29b. Signature and title of certifier	0		29c. License					nth, Day, Year)	
ı	5		> who for	ula		D0	062520		2	/11/0	5	
			30. Name and address of person who co		n 23a) (Type,	Print)	Clar A	WO 5	1 1 7 7 7	or en	20910 ring, MD	
			Maria Kay D'A	00.00			. Gren A	.ve., 5	, , T \	er ph	TING, FID	
	Sta Registr		FEB 1 8 200		K GO	ales)						

State of Maryland / Department of Health and Mental Hygiene 0 0 5

07533 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Feb. Dey 2005 ar 17, **Physician** Alfred 6:35 AM Ε. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Charles Charles County Nursing & Rehab LaPlata If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey). 92 Yrs. **Funeral** Months Deys 1**2** M 2□ F Yrs. Virginia 578-58-4671 March 3,1912 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Merylend Department of Heatth and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or thems 23a or 23a-1 ehow any injury or other traumatic event, the Medical Examinat nust be notified at 10d. Inside City Limits 10e. Stete 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No MD Charles Marbury Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code USA 20658 5375 Georgia Pine Place Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes **②**No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter/Lock Smith US Govt. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nora Patterson Aubrey Posey 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4820 Bicknell Road, Marbury, MD 20658 Dennis Posey/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ◯ Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/23/05 Marbury, Maryland Park Hill Cemetery M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Funegal Service Licensee P.O. BOX 567 LA PLATA, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ULMONA disease or condition resulting in death) Examiner Examine physician end the buriel-trensit or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 ate has been sig pega 2 should b 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 Yes 2 No 1 Yes 2 No this certificate Be 26. Place of Death (Check only one) diractor, 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 9 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: Aftar 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident tha **Director**: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certified Krishan Mathur, M.D 30. Name end address of person who completed cause of death (Item 23a) (Type, Print). 07 31. Date filed (Month, Day, Year) FEB 1 8 32. Registrar's Signature State 2005 It spech Registrar

DHMH 16 Rev 6/95

			- FOI		leg. No. UUD U/334					
	Physicia		1. Decedent's Name (First, Middle, Last) Mary L. Pugh	2. Date of Dea Februar	3. Time of Death 12:10A M					
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
	Ladiiiii	Ç,	107 S. Maple Ave.	La Plata	Charles					
	Funeral		5. Social Security Number 6. Sex $1\square$ M $2\square$ X 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min. May 124 Hrs. 8. Date of Birt Months Days Hours Min. May 124	9. Birthplace (State or Foreign Maryland					
	Director		Usual Residence of Decedent	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, = , = , = , = , = , = , = , = , = , =					
	be filed within 72 hours after death with the Maryland and Hygiene. d other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examin or must be notified at	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or L	ocation a Plata	10d. Inside City Limits					
				1 XYes 2 □ No 10g. Citizen of What Country?						
36			107 S. Maple Ave.	10f. Zip Code 20646	USA					
			1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2√2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: White					
Ö	hours tural'		343 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dece	16b. Kind of Business/Industry						
715	in 72 in "na Medic		(Specify only highest grade completed) (Giv.	e kind of work done during most of working DO NOT use retired)						
21	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnice.		12		Catholic School					
Maryland 21215-0036			17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Murial Loret						
aryl			Joseph A. Bradburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route Number						
				Box 2383 La Plata,M						
ore			20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20c. metery, creation of Disposition of Disposi	ematory or other place)	20c. Location - City or Town, State Arlington, Virginia					
Baltimore,			MANO / 5		<u> </u>					
Ba			Havel C. Echal	² AREHART™ECHOLS FUNER P.O. BOX 567 LA PLAT	A,MD. 20646					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac or respiratory at	rest, Approximate Interval Between Onset and Death					
			Due to (or as a consequence of):							
	p ts	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	death certificate be executed e attending physician and ad for use as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
8760,										
Ö	tificati og phy as the	fedic								
P.O. Box	e law requires that the hes been signed by th je 2 should be detache	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	23d. Date of delivery Month Day Year						
		by	Part II. Other significant conditions contributing to death but not resulting in the	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown						
Vital Records,		Be Completed	Gasto employed (Cef	24a. Was autor perfe						
ital	ician: Th certificete rector, pag		25. Was case referred to medical examiner?	one)						
of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	은	1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 ☐ ER/Outpatient 2 ☐ ER/Outpatient 27. Manner Death 28a. Date of Injury 28b. Time	dence 6 Other (Specify) now injury occurred						
		edical Certification;	1 Matural 5 Pending (Month, Day Year) Injury							
Division			3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		on (Street and Number or Rural Route Number, r Town, State)					
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the To the comp	N	29b. Signature and title of certifier	29c. License number	29d. Date signed (<i>Month, Day, Year</i>)					
,			0.000,001							
4	BIL		30. Name and address of person who completed cause of death (Item 23a) (Type Henry Burke, M.D. P.O. 2539 La							
	Sta	te	31. Date filed (Month, Day, Year) FEB 1 8 2005							

State of Maryland / Department of Health and Mental Hygiene

32.

2005

gistrar's Signature

For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February **Physician** 19, 2005 7:58 P M Young Ramsburg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 19, 1916 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Maryland 214-28-5180 89 Yrs. Director 10d. Inside City Limits Yes 2 □ No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Clothing Industry 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Savannah Court, Walkersville, MD 20c. Location - City or Town, State Union Chapel Cemetery 2/23/2005 Libertytown, Maryland 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick , MD 21702 and . Enter the dis 15%, or complications trait crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failus. List only one cause on each line. Approximate Interval Between Qnset and Death Cardiovascular Disease 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 🗆 No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number February 22,2004. D3516 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Frederick, MD 21701 15 EARLOX Maren 31. Date filed (Month,

State Registrar

			for State RegistraMEND#5perIN			i Marylan √,McCo		artment				-	giene	nni	Č	075	36
	0		1. Decedent's Name (First, Middl									2. Date of De Month	ath Da	.,	V	3. Time	of Death
	Physici /Medic		IRVING	RU	BIN							FEBRUA	RY 1	4, 20	Year 005	5:10	P M
	Examir		4a. Facility Name (If not institution	, give st	reet and nun	nber)		4b. City, 7	Town, or	Location	of Death		40	. County o	f Death		
			SUBURBAN HOSPIT	AL					ETHE					MONTO			
	Funeral		178 ia 01 cur4 475 ber	6. Sex		7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Year) JULY 10, 1914 9. Birthplace (State or Fore Country) NEW YORK					
	Director	-	178_01_4/25. Usual Residence of Decedent	X	M 2□F	90	Yrs.					JULY 10	0, 1	914	NEW	YORK	
	and		10a. State 10b. County			10c. Cit	ty, Town or Lo	cation							1	Od. Inside	City Limits
5-0036	the Marylan 28a-f show	Director	MARYLAND MONTG	OMET	v		DOCK	VTI 1 E								1 Ç Ye	es 2 No
	28a		MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code								10g. Ci	0g. Citizen of What Country?					
	23a or	Ö	6111 MONTROSE ROAD #417 20852								UNITED STATES						
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-1 show avant. The Medical Examination routhed at	Funeral						spanic Origin? (Specify Yes or No- i, Mexican, Puerto Rican, etc.)				14. Race - American Indian,					
	or ite	Ē	Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☑ Never Married 2 ☐ Married 1 ☑ Never Married 2 ☐ Williams (ive www.incomplex)								Rican, etc.)		Black, White, etc. Specify: WHITE				
	ral', c	by	3 Widowed 4 Divorced	3 ☐ Widowed 4 ☐ Divorced If Yes, Give WWII 1 ☐ Yes 2 🌠 No Specify:					•								
	72 hours "natural",	To Be Completed	15. Deceden (Specify only highe				16a. Dece	dent's Usua kind of wor	l Occupa	ation	st of working	10	16b. K	(ind of Bus	iness/In	dustry	
2121	- 3		Elementary/Secondary (0-12)	J. 9, 430	College (1	-4or 5+)	life.	DO NOT us	e retired)		.9					
Baltimore, Maryland 21	filed w Hygier other th				2		S	ELF E	MPLC					SIC			
	be fill tal H d ott		17. Father's Name (First, Middle,	,						18. Moth		(First, Middle,	Maidei				
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avant, Ita Ma		SAMUEL	RUE							SARA			DING			
	2 sh and is m		19a. Informant's Name/Relations				1	-				Route Number	_			'	
	1 and 1 Health am 27 othar tr		LAWRENCE E. RUE	IN,	NEPHI		11205 Place of Dispo			LLLL .		, POTO			208		
	9 5 T		20a. Method of Disposition 1 Burial 2 Cremation		movai from S	State	cemetery, crei	natory or ot	her plac				20C. L	ocation - C	aty or 10	wn, State	
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	permit. Pag Department Important: I any injury o		21. Signat fre of Funeral Service	3.	the	·	1	170 R	<u>ockv</u>	ILLE	PIKE	MEMORIA , ROCK	<u>VILL</u>	HAPEI E, MI	LS, 2	INC. 0852	
			23a. Part L Enter the disease, or shock, or heart faflure. List	complic	ations that ca	aused the deat ach line.	th. Do not ent	er the mode	of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approxim Interval B	Between
	Physician		Immediate Cause (Fina disease or condition		f.	NEU	LMON	IA								Onset and	d Death
	/Medical		resulting in death)	(Due to (or as a consec											
	death certificate be executed e attending physician and id for use as the burial-transit		Sequentially list conditions b. LUNG CANCER														
		Examiner	Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):														
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9	death certifica attending pt d for use as th	Physician/Medicai	IF FEMALE:														
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy								1	23d. Date of delivery Month Day Year					
0	e deg	/sic	1 Yes 2 No 9 Unknown 9 Unknown 5 Uther (specify)														
Ρ.	that the de ned by the a detached i									23a Did t	obacco	bbacco use contribute to the cause of death?					
JS,	The law requires that the te has been signed by the rage 2 should be detached.	Completed by	Part II. Other significant conditions continuing to death bat not resulting in the underlying cause given at Part I.							1 Yes 2 No 3 Probably 4 Unknow							
Records,				_										7			
ec	elaw has b je 2 s											24a. Was	osv	pri	ior to cor	psy finding mpletion of	s available cause of
<u>—</u>												1 ☐ Yes	rmed? 2V No	1 de	eath? Yes	21 No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?		amital: 3 /						e of Death	(Check only o	one)				
of	00 (c) =	P	1 ☐ Yes 2 No	П			ER/Outpatier			4 114		Home 5 Residence 6 Other (Specify)					
ū		Certification;	Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No								28d. Describe how injury occurred						
Division	Attending r death. actor: After by the fune	cat															
<u>₹</u>	or Attendate death Diractor:	rtit								2	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	spital or ours afte naral Dir filled in		200 Contine At Comitati	a Dhyai	eiees Tarks	h 4 1											
	Hos Fur ely	edical	29a. Certifier N Certifyii (Check only 2 Medical	examin	er: On the ba	best of my kno	owledge, deati ation and/or in	n occurred a vestigation,	at the tin in my o	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the ed at the time,	cause(s date an) and man d place, ar	ner as si id due to	ated. the cause)(s)
	To tha Hos within 24 h To tha Fun completely	Mec	29b. Signature and title of certifie	r	and manr	ier stated.		290	License	e number			29d. Date signed (Month, Day, Year)				
	F ≥ E S		1 Alna	St. Signature and title of certifier $D = 0$. License number $D = 0$. License number $D = 0$. Discussion $D = 0$.						660	,		0 / / 4	5/0 C			
7	12		vigue	//	/			,					2	1	/		
	1		30. Name and address of person	1/	1	. 11	m 23a) (Type,	Print)	1///0	5 0	1115	, Rocu	(1111	115	MI	208	52
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State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🖔 07537 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** FEBRUARY 16, NATALIE WYNN 2005 2:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BETHESDA CARRIAGE HILL - BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☐ F Director 125-05-9901 84 28, 1920 NEW YORK JUNE Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MARYLAND MONTGOMERY **BETHESDA** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9412 EAGLE RIDGE DRIVE 20817 UNITED STATES items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🗓 No Specify: Specify 3

Widowed 4 □ Divorced Year or Dates WHITE "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 INTERIOR DESIGNER OWN BUSINESS lled. Peges 1 and 2 should be filed nent of Health and Mental Hygint: If Item 27 is marked other injury gcother traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 BENJAMIN WEINBERG ROSE HERSCHKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH SALTER, DAUGHTER 9412 EAGLE RIDGE DRIVE, BETHESDA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛛 Burial Cremation 3 Removal from State GDN. OF REMEMBRANCE 2/18/2005 4 Donation 5 Other (Spec) CLARKSBURG, MD 21. Signature of Funeral Service/L DOC B EDWARD SAGEL FUNERAL DIRECTION, INC. impo any i prai 1091 ROCKVILLE PIKE, ROCKVILLE, MD nu h 20852 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** SEPSIS OF UNKNOWN ORIGIN resulting in death) /Medical Due to (or as a consequence of) Examiner b DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transit LATE EFFECTS OF RIGHT CEREBRAL HEMISPHERIC STROKE 10 MONTHS Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown The law requires that Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by FEEDING GASTRONOMY TUBE 1 Yes 2 \ \ \ No 3 Probably 4 Unknown MALIGNANT HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 Yes 2XNo Division of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 X Natural death. i Director: And in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 🗌 Suicide within 24 hours after de To the Funeral Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitei 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. Fo the title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and D35579 FEBRUARY 17, 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN J. MILLER, M.D., 6844 TULIP HILL TERRACE, BETHESDA, MD State 31. Date filed (Month, Day, Year) FEB 1 8 2005 Registrar

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pla	Mental arkad c atic eve	To	George E		hardso			Mary		Hester		rsons
_ ~	f Health and Mental Hygiene. item 27 is marked other than "naturel", or items 23s or 28e-f show other treumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (7					and Number or R				Code)
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Baltimore,	important: If any injury or once.		21. Signature of Funeral Service Licen	500	22	2. Name and Addr	ess of Facility	1 Home, 6	P. A.	ide, MD. , MD. 21613
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Hos	Fun	Medical	(Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my	opinion, death occu	rred at the time, da	ate and place, ar	nd due to the cause(s)
DIVISION TO THE HOSPITAL OF Attended Within 24 hours after death	To the Funeral Direc	Mec	29b. Signature and title of certifier	and manner stated.		29c Licen	ise number	2	9d. Date signed	(Month, Day, Year)
F in	- 5		1 and	Hery MD			47924			- 0 5
•			Juli	w of		'/	7/1/7			
			30. Name and address of person who o	completed cause of death (Item シルィー3の AV		Print)	AMBRID	66 ~1	0 2/1	13
	**		/ -			-1	190 115K-10	-16 ///	- 1 6	, ,)
	Sta	_	31. Date filed (Month, Day, Year) FEB 1 7	2005 32. Redistrar's Signa	Jr.	best				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:30 AM February 2005 Robert Norman Robillard 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Laurel Regional Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Jan. 4, Director 014-09-7041 89 1916 Massachusetts Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "neturel", or items 23a or 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Directo Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 IISA 6704 Darby Road Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1∑Yes 2□No 1942
If Yes, Give
Year or Dates: 1945 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced 1945 White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Distributor Wholesale 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H sant: If item 27 Is marked oth Be Joseph Raymond Robillard Hermiama Bernier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2628 Point of Rocks Road, Knoxville, MD 21758 Janet Butler, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. MD Veterans Cemetery Feb. 242005 Cheltenham, Maryland 21. Signature of Funeral Service License 22. Name and Address of FacilityGasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland /an 23a. Part1 Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediale Cause (Final **Physician** Asystole disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dehydration Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal Insufficiency autopsy 1 ☐ Yes 2 ☐ No Dementia or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ EP/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 3 DOA Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 3 🗌 Suicide 6 Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerel I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 105 005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Va

DHMH 17 Rev 1/2001

State

Registrar

Darryl Hill, M.D.

FEB 2 2 2005

31. Date filed (Month, Day, Year)

13635 Baltimore Avenue, Laurel, Maryland 20707

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			Decedent's Name (First, Middle, I	ast)		-					2. Date of D	eath		· · · · ·	3. Time of	Death
	Physicia /Medic		Daniel Lee Ru	ffin J	ſr.						Februa	ry 2	Ži, 20	^{'ear} 05	5:55	РМ
	Examin		4a. Facility Name (If not institution, g	ive street and n	umber)		4b. City,	Town, or	Location	of Death		4	c. County of	Death		
0			7105 Martin Luthe	er King,	_			ındov				I	rince			
7	Funeral			Sex Mg 2 ☐ F	7. Age (In yrs. 43	. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth Jay, Year	61 1	Birthpl Coun	lace (State of try) Ingto	or Foreign
3	Director		577-96-6474 Usual Residence of Decedent	A	43	115.					11-15	1 - 1 9	OT W	asn	Ingto	n DC
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	cation				<u> </u>			10	0d. Inside C	ity Limits
	Man	tor	MD Prince	Georg	ges	La	ndov	er							1 🔯 Yes	2 🗌 No
	th the	irec	10e. Street and Number				10f. Zij	p Code			-	10g. C	itizen of Wh	at Coun	try?	
	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "naturel", or items 23a or 28e-f show event, it a Medical Exactinat must be notified at	Funeral Director	1911 Belle Hav	en Dr.	#104			2	0785				USA	A		
	ed des	nue	11. Marital Status	Armed f		J.S. 13.	Was Dece f Yes, spe	dent of H	ispanic Or in, Mexical	igin? (Spen, Puerto	cify Yes or N Rican, etc.)	lo-	14. Race - Black,	Americ White,		
36	s afte	by Fi	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, C	2 □ No Sive		1□ Yes	≱ No	Specify:	:			Specify:	B1	ack	
8	hour turei	ed b	15. Decedent's	Year or	Dates:	16a. Dece	dent's Heu	al Occup	ation			16h	Kind of Busi	ness/lnc	fuetny	
15	nin 72 n "na	Completed	(Specify only highest of	rade completed		(Give	kind of wo	ork done o	during mos	st of work	ng	100.1	THIS OF BUSIN	116531116	20317 y	
212	d within giene. rr then "	HO	Elementary/Secondary (0-12)	College	(1-4or 5+)	P1	umbe	r				P	rivat	te		
ρ	be filed tal Hygie d other event, t	3e C	17. Father's Name (First, Middle, La	,							(First, Middl		n Sumame)			
<u>ya</u>	2 should be f n and Mental H is marked of reumatic eve	To Be	Daniel L. Ruf						Mar	у Т	homas	3				
, Maryland 21215-0036	es 1 and 2 should b of Health and Ment fitem 27 is marked r other treumatic e		19a. Informant's Name/Relationship Charlene Ruffi	(Type, Print) n/Wif		1911	Be1	1e 1	and Numb Have	er or Rura n Dr	· #10	ber, City)4 L	or Town, St andov	ate, Zip ver	Code) MD	2078
Baltimore,	Pages 1 nent of He int: if iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from	- State	Place of Dispo cemetery, crer	natory`or (other plac	:ө)		ate		_ocation - Ci			
Ē	. Pag tment tent: jury o		* 4 ☐ Donation 5 ☐ Other (Spe	cify)	MD	Vete			,		-2005					1
3a	permit. Pages Department of the importent: if its any injury or of once.		21. Signature of Juneral Service Lic	ensee	-	22	2. Name a	nd Addres	ss of Facili	Tay1	or's	Fun	eral	Hor	ne	
	10240		23a. Part1. Enter the disease, or co	ay		1	722	Nor	th C	apit	ol St	. N	W Was	sh.	DC 2	
			shock, or heart failure. List on	ly one cause on	each line.	itii. Do not ent	ei [rie iiioi	ue or uyiri	y, such as	cardiac	i respiratory	arrest,			Interval Bet Onset and	tween
	Physician /Medical		disease or condition resulting in death)		lications o (or as a conse		nic Al	cohol	Abuse	2						
	Examiner		(Due (o (or as a conse	quence or):										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	o (or as a conse	quence of):										
	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events	C												
o,	<u> </u>	144	resulting in death) Last	Due to	o (or as a conse	quence of):										
Box 68760	eath certificate be eattending physicier for use as the buri	Physician/Medical		d										4-		
9 ×	ertific ding p	/Med	IF FEMALE:	220 Huga a	urteems of execut											
Bo	sath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome of pregn birth 2 Fet gnant at time of	aldeath 3□	Ectopic p						23d. Date of Month		,	Year
P.O.	that the de ted by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		deam 5L	Other (s)	овспу)								
	res that igned by be deta	by Ph	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying (cause giv	en in Part I	1.	23e. Did	tobacco	use contrib	ute to th	e cause of o	death?
rds	quires n sign										1 🗆	Yes 2	2 No 3	☐ Prob	ably 4 🗆	Unknown
00	sw requires been si	olete									24a. Wa		24b. We	ere autor	psy findings	available
Re	The lav	Completed									aut per 1 1 Yes	opsy formed? 2 \(\Brightarrow\)	dea	ath?	npletion of a 2□ No	ause of
ita	or Attending Physicien: The law requires that the death certificate be theredeath. Director: Atter this certificate has been signed by the attending physicie in by the funeral director, page 2 should be detached for use as the but	BeC	25. Was case referred to medical examiner?						26. Place	e of Death	(Check only			¥		
>	hysic his ce	L _O L	1 X Yes 2 No		Inpatient 2	ER/Outpatier			4 🗀 141	ursing Ho	ne 5□Res	sidence	6 Other	(Specify	, at s	scene
n o	iding Physicien: th. : After this certifica tuneral director, t	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	(Mo	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injun Wor			28d. Describe	how inj	ury occurred	i		
Sio	tend death tor: /	cati	2 Accident investigat 3 Suicide 6 Could no	he			М		Yes 2 🗌		204	/C4				
Division of Vital Records,	el or Attendia s after death. si Director: Al	Certification:	4 Homicide determine	buil	ce of Injury - At t Iding, etc. (Spec	ify)	reet, ractor	у, опісе			28f. Location City or T	own, Sta	te)	or Hura.	i Houte Nuit	iber,
_	To the Hospitel or A within 24 hours after To the Funerel Direction completely filled in by	alC	29a. Certifier 1 Certifying	Physician: To t	he best of my kn	owledge, deat	h occurred	at the tin	ne, date ar	nd place,	and due to the	e cause(s) and mann	ner as st	ated.	
	he Ho in 24. he Fu pletel	edical	(Check only 2 Medical Ex	aminer: On the and ma	basis of examin anner stated.	ation and/or in	vestigation	n, in my o	pinion, dea	ath occurr	ed at the time	, date ar	nd place, and	d due to	the cause(s	;)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	11	, =		29		e number			29d. D	ate signed (Month, I	Day, Year)	
	0		+ Hamek to	whall.	MD				CME			Febr	cuary	22,	2005	
OR			30. Name and address of person wh			m 23a) (Type,		11 n-	mn C	+	. D1.		3.5		1 01	0.01
	C+c	10	Yamela E. Situ 31. Date filed (Month, Day, Year)	thou, n.	Registrar's Sign	nature -		TT PE	:пп 2	rreet	Balt	-TIIIOI	e, Ma	ıryla	and 21	ZUI
	Sta Registr		MAR 0 1 200	5	de &	Apres	R					_				

			For State Registrar		State of Ma	aryland		artment of <i>tificate of</i>			/lental Hy	giene	4000	07542
	Physici	an		e (First, Middle, Las	·						2. Date of De			3. Time of Death
	/Medic	al	DONALD	L. REES				4b. City, Town,	or Location	n of Death	FEB		2005 County of Dea	
	Examin	er	Peninsula	RAGIONAL	Medical	Com	les	54	1/15/4	M		-	Hoon	
	Funeral		5. Social Security N	11	7. Ag	e (In yrs. la:	st birthday) Yrs.	If Under 1 Yea Months Days		er 24 Hrs. Min.	B. Date of Bi	rth ay, Year	9. Bi	rthplace (State or Foreign ountry) LTIMORE, MD
	Director		212-30- Usual Residence o		X.	70					DEC.Z,	1734	+ DAI	LITHORE, MD
	the Marylan 28a-f show	J.	10a. State	10b. County			Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 X No
	the M 28a-f	Directo	DELAWARE 10e. Street and Nu	SUSSEX		6	GREENW	10f. Zip Code				10g. Ci	itizen of What C	
	23e or	al Di	10975 B	LACKSMITH	SHOP ROAL)			95 0			3	USA	
	72 hours after death with the Maryland Ineturel; or Items 23e or 28e-f show dical Exam her must be notified at	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	. 13.	Was Decedent of 1 Yes, specify Cu	Hispanic (ban, Mexic	Origin? (Sp can, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh	
2	urs afti	by	1 ☐ Never Marr 3 ☐ Widowed	ried 2 Married 4 X vivorced	1 X Yes 2 ☐ f If Yes, Give Year or Dates:	No		1 □ Yes 2 😿 No	o Specii	fy:			Specify: W	HITE
	72 hours "neturel", dical Exa	eted	(Spec	15. Decedent's Ed cify only highest grad			16a. Deced	dent's Usual Occi	upation e durina m	ost of worl	kina	16b. h	Kind of Busines	s/Industry
4	filed within Hygiene. Ither then "	Completed	Elementary/Seco		College (1-4or 5	5+)		kind of work don DO NOT use retir LLWRIGH'			9		STEEL M	ILL INDUSTRY
7	2 should be filed within and Menta! Hygiene. ie marked other then eumatic event, the Mental corent, the Men	Be Co		(First, Middle, Last)					1	ther's Nam	ne (First, Middle	, Maidei	n Sumame)	
yla	should be ind Mental marked o umatic eve	To B	KENNET	H VIRGIL	REESEY				I	RENE	SANTME	I.R		
	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. I feel file at 1884 show filem 27 is marked other then "neturel", or items 23e or 28e4 show other treumatic event, the Medical Exam per must be notified at			lame/Relationship (7	,, ,			ng Address (Stree						-
נ ט	t Health tem 27 tother tre		20a. Method of Dis			20b. Pla	ce of Dispo	DUNDAL sition (Name of	1	NUE,	Date		D 2122 ocation - City o	
2	Pages nent of I ant: if ite ury or of			Cremation 3 ☐ 5 ☐ Other (Specify		EAST	ERN SHO	RE CREMAT	ORIUM	02/	21/05	LEV	VES, DEI	LAWARE
Dall	permit. Pages 1 and 2 Department of Health a importent; if item 27 is any injury or other tre once.		21. Signature of Fe	uneral Service Licen	Rell	6	PA 20	RSELL FUNDAMS ST	RAL HOREET	MES & BRIDGE	CREMATOR	RIUM, E 19	HARDESTY 933	CHAPEL
	1 1		23a. Part1, Enter shock, or hea	the disease, or comp art failure. List only o	lications that caused one cause on each li	the death.								Approximate Interval Between
ı	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a 5 tm	-lec				_				Onset and Death
	Examiner			ſ	Due to (or as	a conseque	ence of):							
	D =	ner	Sequentially list co if any, leading to in cause. Enter Under	mmediate	Due to (or as	a conseque	ence of):							
	ecute and I-trans	Examiner	that initiated event resulting in death)	S	cDue to (or as	3 00000000	anco of):							2
Š	ificate be executed physician and as the burial-transit	sal E		l	d	a 00/100qu0	31100 01):							
0	- FB -	Aedical	IS SELVALE		u									
5	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceder in the past 12	it pregnant	23c. If yes, outcome 1☐Live birth	2 Fetal c	death 3	Ectopic pregnan				-	23d. Date of do	elivery Day Year
	the de y the a ached f	ysic	1 ☐ Yes 2 9 ☐ Unknown	No	4□Pregnant at 9□Unknown	time of dea	ath 5∟	Other (specify)						
n n	ss that gned b	by Pr	Part II. Other signi	ificant conditions co	ontributing to death b	ut not result	ting in the u	nderlying cause g	iven in Pai	rt I.	23e. Did	tobacco	use contribute	to the cause of death?
<u> </u>	w require been się should b										1 🗆	Yes 2	2 DNo 3 □ F	Probably 4 Unknown
ט	has b	Completed										s an opsy ormed?	24b. Were a prior to death?	autopsy findings available completion of cause of
2	iysicien: The l is certificate ha director, page	0	25. Was case refe	rred to medical					26 Dia	aca of Doa	1 ☐ Yes	<u> 2</u> □ N		s 2 No
_	Physicion this cer al direct	To B	examiner?	/	Hospital: 1 Inpatie	ent 2 E	R/Outpatier	nt 3□ DOA	thor				6 Other (Sp	ecify)
=	ling PI		27. Manner of Dea 1 Natural	5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	W	ork?		28d. Describe	how inju	ury occurred	
200	ei or Attending Phy s after death. i Director: After this d in by the funeral d	ertification:	2 Accident 3 Suicide	investigation 6 Could not be determined	28e. Place of Inj	ury - At hom	ne, farm, str	M 1	Yes 2	∐ No	28f. Location	(Street a	and Number or I	Rural Route Number,
Ś	s after ai Dire	Certi	4 Homicide	Gotomino	building, et	c. (Specify)					City or To	wn, Stat	te)	
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funeral Director: After this certification in the funeral director, to the funeral director, and the funeral director, the funeral director director, the funeral director director, the funeral director director director, the funeral director d	edical (29a. Certifier (Check only one)	1 Certifying Ph 2 ☐ Medical Exam	ysician: To the best liner: On the basis o and manner st	f examination	rledge, deat on and/or in	h occurred at the vestigation, in my	time, date opinion, d	and place leath occu	, and due to the rred at the time	cause(: , date ar	s) and manner and place, and du	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and	d title of centillor					nse numbe				ate signed (Mor	nth, Day, Year)
	W.		111	0/-	-mo)		198	4879	7		> Z	12010	5
	200			lress of person who	completed cause of o	leath (Item :	23a) (Type,	D 5 Print) 1.2180/	6000	Tos	uth mi	D		
• •	Sta	te	31. Date filed (Mo	FEB. Year 21	32. egistr	ar's Signatu	ire	1	UKEY	1166	WIN AN			
	Registr	ar		ED 60 20	THE CUI	w l	× A	pail !						

			For State	State of Marylan				Mental Hygi	ene	0-11-10
			Registrar	M)	Cer	tificate of	Death	Re-	g. No. UU	0/543
	Physici		1. Decedent's Name (First, Middle, La:	Smith				Month Feb.	Day Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give College View			4b. City, Town, o	Location of Death		4c. County of Dea	th
			5. Social Security Number 6. S		la et histhday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Frederi	
	Funeral Director			M 201 F /00	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) 9. 61 1904	thplace (State or Foreign ountry) Md.
	p ,		Usual Residence of Decedent	10-0	Ţ			7		
	f show	ō	10a. State 10b. County Md. Freder		y, Town or Lo	•				10d. Inside City Limits 1
	the A	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	/
	h with	a D	321 Madiso	n St.		2170	01		U.S.A.	•
	ems ems	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
36	toges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If I tem 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinational be notified at	by Funeral Director	1 Never Married 2 Married 3 ØWidowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 Z No	Specify:	,	Specify: 3	/
215-0036	2 hou	ted	15. Decedent's Ed	ducation	16a. Deced	ient's Usual Occup	ation	1	6b. Kind of Business	/Industry
218	ithin 7 98.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	_	kind of work done	during most of wor d)	King	Private 1	Families
121	filed w Hygier other th		17. Father's Name (First, Middle, Last)		DUN	nestic	19 Mothade Nan	ne (First, Middle, M		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be	William h	Ihite			,		ohnson	
ary	should and Meni s marks	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health a lem 27 is		Dorothy M. 6	Onley	321	Madison	st F	rederic		1701
Baltimore	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau pnce.		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State	emetery, cren	sition (Name of natory or other place			Oc. Location - City or	4. /
Ęï			* 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		22	Name and Addre	ss of Facility		vederick	
Ba	permit. Departr Importa any inje		> pary L. F	ollis	6	ARY L. A	SOUTH ST	FREDER	ick mo	21701
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not ente	er the mode of dyin	g, such as cardiad	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Hynn	etins	(1/1 C	1 did VAS	cales Di)ease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):		, , , ,	,	, ,	1
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
68760,	icate t physies the t	dlcal	•	d						
Box (death certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
Э. В	e death he atte	Physiclan/Me	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year
P.0	that the dened by the and detached f		9 ☐ Unknown Part II. Other significent conditions of		ulting in the ur	aderiving cause giv	en in Part I	23e Did toba	acco u se contribute t	the cause of death?
Records,	og de	d by	,	on the death of the trees.	21.119 11 11 10 11	idonying oxaso giv	on art arti.	1 Tes		robably 4 Unknown
000	aw requir s been si 2 should	Completed						24a. Was an		utopsy findings available
- Re	The lav ate has page 2:	Com						autopsy perform	ed? death?	completion of cause of 2 □ No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one	_	
of	Physician: this certificatal director, I	2	1 Yes 2 No		ER/Outpatien		Nursing H		nce 6 Other (Spe	ocify)
	ding Ih. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor M 1 □	yat k? Yes 2 □ No	28d. Describe hov	v injury occurred	
Division	Attending or death. ector: After by the fune	Certification;	3 Suicide 6 Could not b	28e. Place of Injury - At ho	me, farm, str				eet and Number or R	ural Route Number,
ā	ital or irs afte ral Dir led in		4 Homicide	building, etc. (Specify	·//			City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 burous after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier Certifying Ph (Check only one)	ysicien: To the best of my kno niner: On the basis of examinat and maynar stated.	wledge, death tion and/or inv	n occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	ro the	Mec	29b. Signature and title of certifier	and maringi stated.		29c. Licens	e number	29	d. Date signed (Mpn	h, Day, Year)
)	,- > - 0		· (AMA	(XIm-	M	0			21.	23/05
	6			completed cause of death (Item	23a) (Type,	Print) C	LN C ICH	Marie	10 11701	
	<i>I</i>		CASPER El. CLIN			P -D FIG	CUELICK	MARYLAN	VU SIIV	
	State 31. Date filed (Month, Par Your) 3 2005 32. neistrar's Signatus.									

		1 - For Amend Item 4a	State of N per me (Marylan 3841 3	d / Depa -18-05 <i>Cer</i>	rtment o tas tificate	of Heal	th and N a <i>th</i>	lental Hyوا ا	giene 2 Reg. No.	005	07544
o.		1. Decedent's Name (First, Middle, Las							2. Date of Dea Month	ıth		3. Time of Death
Physicia /Medid			IZABETH	SNOO	K				FEBRUAF		2005	7:45p M
Examin	er	4a. Facility Name (If not institution, give 700 TOLL AVENUE 70	0 To11 H	ouse A		FREDE	RICK	tion of Death		1	unty of Death ERICK	
Funeral Director		5. Social Security Number 578-07-4057 Usual Residence of Decedent	ex	Age (In yrs. I	last birthday) Yrs.	If Under 1 Y		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Day MAY 1,	r, Year)		place (State or Foreign intry) ryland
land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
Mary B-fsh iffed	tor	Maryland Frederi	ck		Thurm	ont						1 🗌 Yes 💥 No
or 28	Director	10e. Street and Number	1 D 1			10f. Zip Co		1700		10g. Citizer	of What Cou	intry?
s 23a	ral	6134 Mountainda			0 401			1788		Unit		ates
permit. Pages 1 and 2 should be Illed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, I'm Modical Examiner must be motified at 900ce.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	s? No	li li	Yes, specify	Cuban, Me	ecify:	pecify Yes <i>or</i> No- Rican, etc.)		Race - Ameri Black, White ecify: Wh	
72 ho	eted	15. Decedent's Ec	fucation de completed)			ent's Usual C		most of work	cina	16b. Kind	of Business/Ir	
vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. L	OO NOT use r	retired)		9	Count	v Caha	ol Board
illed v Hygie thar t		12 17. Father's Name (First, Middle, Last)	<u> </u>		Care	teria		-	e (First, Middle,			or poard
hould bat d Mental I narkad of natic eva	To Be	Frank 19a. Informant's Name/Relationship (rris	105 Mailin	a Add (C		Cora	Ellen	Bown	nan	in Onda
nd 2 silth an 27 is r			Daughter	r		-			ral Route Numbe / Frede:	-		1702
s 1 ar f Hea itam (1 8	20a. Method of Disposition		20b. P	lace of Disposemetery, cren	sition (Name	of		Date		ion - City or T	fown, State
permit. Pages Department of mportant; If it any injury or o		1 Burial 2 Cremation 3 C '4 Donation 5 Other (Specify		TA I				102/22	2/2005	Frede	rick,	Maryland
permit. Departn Imports any inju		21. Signature of Funeral Service Licen	1800		\ \ ×	. Name and A		SL				es, P.A.
		23a. Part1. Enter the disease, or com	olications that caus	ed the death					ike/ Fro		ck, MD	21702 Approximate
Physician /Medical Examiner		shook or leart failure. List only Immediat: ause (Final disease or condition resulting in death)	a	is ine. Situation as a consequence.	mal	Asp	lyx	ia				Interval Between Onset and Death
To the Hospital or Attending Physician: The law raquires that the death certificate be axecuted within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequal								
ificate g phys	edic		. d									
the death cert the attendin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	Ideath 3	Ectopic pregr Other (speci				230	. Date of deliv Month	very Day Year
law raquires that as been signad b	by	Part II. Other significant conditions of	0 1		ulting in the ur	_		Part I.	23e. Did to	-	,	the cause of death?
Tha law ra	Completed						-		24a. Was autop perio 1 X Yes	an 2 sy rmed? 2 No	24b. Were aut prior to co death? 1 AYes	copsy findings available ompletion of cause of 2 No
sician: T	Be c	25. Was case referred to medical examiner?	Hospital:				Other		th (Check only o			
Phys r this aral dii	To :	1 XYes 2 No 27. Manner of Death	1 Inpa		ER/Outpatien 28b. Time of		. Injury at	☐ Nursing H	ome 5 ☐ Resident	ow injury o	ccurred </td <td>SCENE</td>	SCENE
or Attending Phy after death. Diractor: After thii in by the funeral or	ation	1 ☐ Natural 5 ☐ Pending 2 🔀 Accident investigation	A	Day Year)	Found 7:45	PM	Work? 1 ☐ Yes	2 1 No	caugi	rt in	wheels	chair
To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certified completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not by 4 Homicide determined	28e. Place of building,		ome, farm, str		rffice		28f. Location (5 City or Tox	Street and A	lumber or Run 700 101	ral Pouto Mumber
e Hospi 124 hour E Funar letely fill	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exam	ysician: To the be niner: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred at trestigation, in	the time, da my opinion	te and place, , death occur	and due to the red at the time,	date and pla	d manner as ace, and due	stated. to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	0		0	29c. L	icense num	ber			igned (Month,	
		> Carol Ha	llan	Mag	#	OCM	Œ			FEBR	UARY 19	9, 2005
3		30. Name and address of person who	completed cause of	f death (Item	23a) (Type,	Print)						
		CAKOL HALL	TUNG	otracia Ciara	tura -	111	Penn	Stree	t Balt	imore	, Mary	land 21201
Sta Registr		31. Date filed (Month Par Year) 2	2005 32.	strar's Signa	15 1	2016						

		1	For State Registrar	State	of Maryland		artment of H		and M	ental Hygie	0	005	078	7 1 27		
			Decedent's Name (First, Middle	e, Last)					-	2. Date of Death	- Tana	اليكاما	3. Time of D	yeath U		
	Physicia		Jack Va	shon Stew	art					Month February	Day 17	Year 2005	0740	М		
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of				ty of Death	1 07 10			
		,	Washington	Adventist	Hospita	1	Ta	koma	Park		M	ontgor	nerv			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la:		If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, Y			lace (State or	Foreign		
	Director		339-22-7319	1 XM 2 ☐ F	79	Yrs.	World's Days	Hours	- 1		1925_	1 -	sh. DC			
	pu ,		Usual Residence of Decedent		10.00	Town or Lo				•						
	aryla	_	10a. State 10b. County		Tuc. City,	Town or Lo	ocation					1	0d. Inside City 1 XYes 2			
	8e-f	ctc		ce George	s's		Lewi	sdale	·							
	or 2	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of	f What Coun	try?			
	eth v	20	7002 - 20					20783				ited S				
	er de tems	Funeral	11. Marital Status	Armed f		. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White,				
36	s afte	byF	1 XNever Married 2 Mar 3 Widowed 4 Divorced	. If ❤es, G	2 □ No aive		1☐ Yes 2☐ No	Specify:			Spec	ity: Bla	ack			
21215-0036	hour	b b		Year or	Dates:	16a Doso	dent's Usual Occupa	ntion		1 10	h Kind of	Business/Inc				
<u>ب</u>	n 72 "na Pedic	Completed	(Specify only highe	st grade completed		(Give	kind of work done a DO NOT use retired	luring mos	t of worki	ing	b. Kilid of	Ousilless/lin	Justry			
12	with ene. thar	E C	Elementary/Secondary (0-12)	College	(1-4or 5+)		Pered				C.	16 0	. 1			
0	filed Hyg other ent,		17. Father's Name (First, Middle,	Last)			Busi		er's Name	(First, Middle, Ma		<u>1f-Emp</u> ame)	поле			
an	ld be ental ked o	To Be	(Unknow	n) Stewar	•+					Sue Gr	neein					
Maryland	shou mar mar	-	19a. Informant's Name/Relations	,		19b. Mailii	ng Address (Street a	and Numbe	er or Rura				Code)			
Š	nd 2 lith a 27 is r tret		Margaret A. Wy	nn/First	Cousin	1039	0 Wilshir	e Blv	d.,	#1017 L	os An	geles.	CA 90	024		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any figury or other traumatic event, the Madical Examinating results any once.		20a. Method of Disposition		20b. Pla		osition (Name of matory or other place					n - City or To				
9	Page ent o nt: if		1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ii State		ek Cemete		1221	2005	LIa a b	instan	n.C			
₫	artm orter Inju				1							ington	I, DC			
ñ	permi Depa Impo any it) lether I	Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019												
			23a. Party. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the death.	Do not ent	ter the mode of dying	g, such as	cardiac c	or resultratory arres	t,	DO 20	Approximate			
	Objectation .		Immediate Cause (Final	only one cause on	each line.	sl nl	tomaril	0 1	hos	. 1			Onset and De			
	Physician /Medical		disease or condition resulting in death)	a	o (or as a cons	nu	MADUS	1	IW	UC		- 1				
	Examiner				(). 43 4 55.15	II Kli	cholia	PIDN	NIC	A						
		ē	Sequentially list conditions,	b. Due t	C (or as a conseque	ence of):	1100 V V	1	1	11						
	uted d ansit	E	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S		- (,	11 Coan	001	OKAC) thu						
á	exec on an	Examiner	resulting in death) Last	Due to	o (or as a conseque	ence of):	- Congre	باساسا								
8760,	cate be executed physicien and the burial-transit	dicai		d					4	,						
9	tifica ig ph as th	Φ.				-					-					
Вох	death certifi e attending i d for use as	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregnan		⊒Ectopic pregnancy				23d. D	Date of delive	ery			
	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of dea		Other (specify)				y	Month	Day Ye	ear		
P.0	that the death certific ed by the attending (detached for use as	Physician/M	9 🗆 Unknown	9000	nown		,									
	iaw requires that as been signed b 2 should be deta	by F	Part II. Other significant conditi	ons contributing to	death but not resul	ting in the u	inderlying cause give	en in Part I		23e. Did toba	cco use co	intribute to th	ne cause of de	ath?		
prd	v require been si should b	ed		- ///	W. C	MILL	HICLES	14		1 🗌 Yes	2 🗆 No	3 🗌 Prob	ably 4 □Ur	iknown		
Records,	has be ge 2 sho	piet	Ca	LOLLON	woha	lty.	N	/		24a. Was an autopsy	241	. Were auto	psy findings av	vailable		
ž	9 - 9	Completed		01410	1 100	Um	moresto	alles	Mous	performe	No No	death?		230 01		
Vital	ician: Th certificate ector, pag	BeC	25. Was case referred to m - ca		V July	1311	of lacy !	26/ Place	of Death	(Check only one)						
>	Physician: this certific ral director,	To	examiner? 1 Yes 2 No	Hospital:	patient 2 E	R/Outpatie	nt 3□ DOA Othe	4 □ NL	rsing Ho	me 5 🗆 Residen	ce 6 🗆 O	ther (Specifi	Y)			
n of			27. Manner 1 ath 1 atural 5 Pendi		e of Injury onth, Day Year)	28b. Time o Injury	of 28c. Injury Work	/ at k?		28d. Describe how	injury occ	urred				
<u>Ö</u>	Attending r death, ector: After	atic	2 Accident invest	igation			M 1 []	Yes 2	No							
Division	for Attendest efter dest Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	nined 289. Pla	ce of Injury - At hor Iding, etc. (Specify)	ne, farm, st	reet, factory, office			28f. Location (Stre City or Town,	et and Nur State)	nber or Rura	l Route Numb	ΘΓ,		
	Hospitel or 24 hours efte Funerel Dir tely filled in															
	• Hospitel 24 hours • Funerel etely filled	edicai	(Check only 2 Medica	Examiner : On the	basis of examination	rledge, deat on and/or in	th occurred at the time	ne, date ar pinion, dea	nd place, ath occurr	and due to the cau ed at the time, date	se(s) and i and place	manner as si e, and due to	ated. the cause(s)			
	To the Hospitet or Attent within 24 hours efter deatl To the Funerel Director: completely filled in by the	Med	one) 29b. Signature and title of certific	and ma	anner stated.		29c. License					ned (Month,				
	ĕ ₹ 8							11	16	7	()	117/	11-			
Δ	(II)		30. Name and address of person	who completed	use of death (line)	23a\ /T	Print\	20	17	-/	x/	11/6	/ J			
1	(15)		DR AASRE	EN K	ANC O	23a) (1ype,	O CARRO	//	AVE.	TAKOM	A	POPL	M.120	912		
	Sta	te	31. Date filed (Month, Day, Year) 3	Registrar's Signati	101	- CAME	// /	115.	11711 0111	//_/	17/	, 10	- 1 - 4		
	Regist		FEB 2 2	2005	Due 1	Los	W.									

Amend Item I per phys 8841 3-7-05 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. New 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, **Physician** ebramy 19, 200 Year Ε. 05155N /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA ロッカル Work 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1☑M 2□F 312-36-3699 Yrs. 12, Director 6 1937 Illinois Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentat Hygiene. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits is 23s or 28a-f show PA Berks Blandon 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 211 Hope Drive 19510 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1 Never Married 2 Married ŏ 1 ☐ Yes 2 ☒ No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Communication 12 Machinist ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lester Stellhorn Lillian Rackley ۵ 19a. Informant's Name/Relationship (Type, Print)
WITE St 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wire Beverly A. (Linville) Stellhorn 211 Hope Drive, Blandon, PA 19510 Health Item 27 i other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
any Injury or ot Maidencreek Twp., PA 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maidencreek Cemetery 2/24/2005 * 4 ☐ Donation 5 ☐ Other (Specify) GALLMAN SONOSKI FUNERAL HOME, 21. Signature of Funeral Service Licensee MOUSED INC. Castre 910 CHESNUT ST. READING, PA. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RI 20 minutes rest, rigitar disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit sping, 45 that initiated events resulting in death) Last Due to (or wa consequence of): Box 68760, nding physician Physician/Medicai as the IF FEMALE: USB 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. F , the 1 Yes 2 No 9 Unknown s been signed by the should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Nnpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) After thi tuneral 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pendina 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined within 24 hours after To the Funerel Direct 4 - Homicide 1100 To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 , M.D. 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Worth Walte Street Baltimore, Mars Sames 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 3 2005 Registrar

		State of Maryland / Department of Health and I State of Maryland / Department of Health and I Certificate of Death		giene 005	07547
0		Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
Physicia		ROBERT LARUE SCHUYLER	Month	Day Year 4 24, 2000	
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
LAGINIT	-1	Peninsula legional medical Center Salisbury	,	Wico	v2://
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		h 9. Bi	rthplace (State or Foreign
Director		212-66-1680 1 M 2 F 46 Yrs. Months Days Hours Min.	03-22-1		MINGTON, DE.
p ,		Usual Residence of Decedent			
larylan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2√☐ No
vith the Maryla or 28a-f shot	Director	MD WICOMICO PARSONSBURG			
72 hours after death with the Maryland natural; or Items 23e or 28e-f show licel Exameter instituted at	ä	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
s 23a	Funeral	7453 RACHEL LANE 21849 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	See at Ven of Ne	USA - 14. Race - Arr	
ier dea Items	un.	Armed Forces? If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, Wh	
irs af	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates: ARMY 1 ☐ Yes 2 ☐ No Specify:		Specify:	WHITE
2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation	1	16b. Kind of Busines	s/Industry
C 1 2	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work done during m	rking		•
filed within Hygiene. other than " ent, I've Mer	E	9 PLUMBER		SELF EMPL	OYED
be filed ntal Hygi ed other event, II	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	me (First, Middle,	Maiden Sumame)	
uld b Wents rrked	To E	HARVEY EARL SCHUYLER BETTY H	ASTINGS		
permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re	ural Route Numbe	ar, City or Town, State,	Zip Code)
and 2 ealth n 27		CYNTHIA BRATTEN - SISTER P.O. BOX 84 PARSONSB	URG, MAR	YLAND 2184	9
of He roth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State
Pages ment of ant: If its ury or o		'4 □Donation 5 □Other (Specify) CREMATORY OF DELMARVA 01-	27-2005	DELMAR, DE	LAWARE
permit. Departr Importa any inju		21. Signature of Foregraf Service Licensee 22. Name and Address of Facility B	OUNDS FU	NERAL HOME	, INC.
3 82 E 8 8		The sea fell selling 705 EAST MAIN STRE	EI, SALIS	BURY, MARYL	AND 21804
111		23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardial shock, or heart failure. Little only one cause on each line.	c or respiratory ar	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	m	M	Onset and Death
/Medical		resulting in death) Due to (or as to insequence 4f):			
Examiner	1	Sequentially list conditions D.			1
י פ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	-	
acute ind trans	Examiner	that initiated events c.	lone	2	
be executed sician and burial-transit		Due to (or as a consequence of):			
at y di	dical	d			
The law requires that the death certific tentific the has been signed by the attending page 2 should be detached for use as:	hysiclan/Med	IF FEMALE:			1
ath c	lan/	23b. Was decedent pregnant in the past 12 months?		23d. Date of d	elivery Day Year
by the a	/sic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)			,
hat It	۵.	Part II. Other signifigant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
signed I	l by	Multimer alme-		_	Probably 4 DUnknown
w requir been si should I	ompleted	160	-		
e law has b	Idu		24a. Was autop	an 24b. Were a prior to death?	autopsy findings available completion of cause of
	S	-C/T	1 ☐ Yes	2 € NO 1 □ Ye	s 2 No
Physician: The this certificate ral director, pag	Be	examiner? Hospital:	ath (Check only o		
this al dii	. To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing N	-	dence 6 Other (Sp	ecify)
After fune	ertification:	1 Natural 5 Pending (Month, Day Year) Injury Work?	ZOU. DESCRIBE	low injury occurred	
tten deat ctor: / the	ical	3 Suicide 6 Could not be	28f Location /	Street and Number or I	Rural Route Number
after Dire	ertii	4 Homicide determined building, etc. (Specify)	City or Tov	wn, State)	raid raid or
spita lours neral	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the	cause(s) and manner	as stated
e Ho 24 h e Fu letely	edical	(Check only 2 Medical Examiner) On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			
To the Hospital or Attending R within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Me	29b. Signature and the of certifier 29c. License number		29d. Date signed (Moi	nth, Day, Year)
Jul		IN / MANA NEGRADIST DE	2/11	1/27/	85
1111	,	30. Name and address opperson who completed gause of death (item 23a) (Type Print)	1 1	1) 21	Po 11
1 Vot		1340 John Awym CT (Ph/SSUR)	1 64	1/2/18	104.
Sta	te	31. Date filed (Month, Day, Year) JAN 2 7 2005 32. Refistrar's Signature	1		
Registr	ar	JAN 2 7 2005 Marie B. Agardi.			

KoBert L. Schuyler 212-66-1680

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 15, ANNA SUKHENKO 2005 11:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROCKVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year SEPT 16, MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 🛛 F 89 1915 UKRAÍNE **Director** 216-21-5536 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f shower than "natural Examiner must be notified at 1 XYes 2 No Funeral Director MARYLAND MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 17060 KING JAMES WAY APT. 519 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Be Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth any injury or other traumatic svent ones. AARON PISKUN HINA (UNASCERTAINABLE) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIKHAIL GITELMAN/SON-IN-LAW 14671 BROUGHAM WAY, GAITHERSBURG, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) JUDEAN MEM. GARDENS 02/17/2005 OLNEY, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION,
1091 ROCKVILLE PIKE, ROCKVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOGENIC SHOCK /Medical Due to (or as a consequence of): **Examiner** HEART FAILURE Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed SEVERE AORTIC STENOSIS Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 9SH 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown þ signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy performed? 2 X No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061681 FEBRUARY 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT KIRKCALDY, M.D., 9901 MEDICAL CENTER DR., ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 18 2005 Registrar

	1	State of Maryland / Department of Health and N 1- State Registrer Certificate of Death	-	giene	07549								
Physiciar /Medica	า ที่	1. Decedent's Name (First, Middle, Last) CATHERINE SIMONE	2. Date of De Month	ath Day Year Ary 14, 2005									
Examine Funeral Director		4a. Facility Name (If not institution, give street and number) BON SECOLDS HOSPITAL BALTIMO 5. Social Security Number 6. Sex 1 M 2X F 86 Yrs. 4b. City, Town, or Location of Death BALTIMO Town, or Location of Death BALTIMO Months Days Hours Min.	8. Date of Bir	th 9. Birth y, Year) 9. Birth 4, 1918 Wash	nplace (State or Foreign								
e Maryland	_	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Maryland Baltimore Catonsville			10d. Inside City Limits 1 ☑ Yes 2 ☐ No								
ath with th	<u> </u>	10e. Street and Number 719 Maiden Choice Lane 21228		U.S.A.									
within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Madical Examiner coust by recitified at	2	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerton U.S. A med Forces? 1 □ Yes 2 ☒ No Specify:	pecify Yes or No o Rican, etc.)		ican Indian, b, etc. ite								
ire, INTALYIGITION ZIZIO-UUJO s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant, the Medical Examination is the ricilling at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years 16a. Decedent's Usual Occupation (Give kind of work done during most	rking	Own Home	ndustry								
yidirid	10 Be	George Vincent Repetti Margare	et Slat	Maiden Sumame)	2								
Pages 1 and 2 sh nent of Health and nent of Health and int: If itam 27 is m ury or other traum		19a. Informant's Name/Relationship (Type, Print) Dominic V. Simone/Son 10500 Rockville Pike, #216, Rockville, MD 20852 20a. Method of Disposition 1\overline{\Delta}\text{Burial 2 \substitute Cremation 3 \substitute Removal from State}} 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 \substitute{\Delta}\text{Comparison} 5 \substitute{\Delta}\text{Other (Specify)} 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10500 Rockville Pike, #216, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Ceme. 102/18/2005 Silver Spring, Maryla											
permit. Pages Department of important: If it any injury or o		21. Signature of Funeral Service Licensee A part. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart fail ist only one cause on each line.	RAL HOME	INC. Ilver Sprin	g, MD 20904								
Physician /Medical Examiner		shock, or heart fail List only one cause on each line. Immediate Cause hal disease or condition resulting in death) a. Outte Myo cardial in Due to (or as a consequence of):	face	tion	Approximate Interval Between Onset and Death								
pring pe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Corvingry Cattery Disease Due to (or as a consequence of):												
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of deli Month	very Day Year								
w requires that the standard been signed by should be deta	y y	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to Yes 2 No 3 Pro									
	Completed	<u> </u>	24a. Was auto perfo 1 Yes	prior to death?	topsy findings available completion of cause of								
ng Phys	0 0	25. Was case referred to medical examiner? Yes 2 No	lome 5□ Resi	dence 6 Other (Specification)	rify)								
To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fundation of t	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Number or Ru wn, State)	ral Route Number,								
the Hospi hin 24 hou the Funer npletely fill	ледісаі	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the urred at the time,	date and place, and due	to the cause(s)								
12 E	- 1	29b. Signature and title of certifier Rope R. Cruz m. S Dod 303 53	5 7	29d. Date signed (Month	, ,								
		Nonth R. CM S m. S D0030353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSTA R. CR4Z M-D BON SECO	URS	HOSPITA									
State Registra		31. Date filed (Month, Day, Year) FEB 1 8 2005 Segistrar's Signature Segistrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Amended 2/22/05 item #17/wchartificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stout, Sr. Stanley Kent /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbur 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F Months Yrs. Director Honduras 223-38-1638 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21804 714 Edgar Drive Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: U.S. Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 🏋 Divorced 'naturel' White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ne filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Salisbury University Kenneth Shirley Stout 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Heelth and Mental Stout Blanche White Kenneth Shinley ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Heelth a Importent: If item 27 Is 21804 714 Edgar Drive, Salisbury, Maryland Lisa Ann Stevenson (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery February 25,2005 Hurlock, Maryland anature of Funeral Service Licensee Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Road, Salisbury, Maryland Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it may leaving to innectate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical phys the L 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. sign 1 be 1 Yes 2 No 3 Probably 4 ZUnknown bluods Completed 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 Yes 2 No 2 No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 10 1 Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State

Registrar

STOUT.

SIMONA ENG DO 1008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISHURY Md. 21801

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Mai	ryland / Depa <i>Cei</i>	artment of		and Me		jiene,	005	07551
		Ю	Decedent's Name (First, Middle, Last)			_		2	. Date of Dea	ith		3. Time of Death
	Physici /Medio		WILLIAM	EARL	SAUB	LE			Month 2	Day	2005	7:35 p ^M
	Examir		4a. Facility Name (If not institution, give s		Ctr	4b. City, Town,	or Location of	f Death		4c. C	County of Death	-
			Carroll Lutheran V				tminst				Carrol	1.
п	Funeral		5. Social Security Number 6. Sex 219-01-0310	.M 2 F	(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days			B. Date of Birth Month, Day April	Year)	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent		86 Yrs.				April	13 1	918	MD
	/land		10a. State 10b. County		10c. City, Town or Lo						1	10d. Inside City Limits
	Man-fish	ţċ	MD Carro	,TT	West	minster						1 X Yes 2 ☐ No
	or 28	ire	10e. Street and Number			10f. Zip Code				10g. Citize	en of What Cou	ntry?
	23a	Funeral Director	300 St. Mark Way			2	1158				USA	
	er deg	nue		Was Decedent Ev Armed Forces?		Was Decedent of f Yes, specify Cui	Hispanic Orig ban, Mexican,	in? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14	4. Race - Americ Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ \ No If Yes, Give Year or Dates:	١ .	1 ☐ Yes 2 🕱 No	Specify:			5		hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28a-f show Its Marical Examiter mast be malified at	ed	15. Decedent's Educ		16a, Decer	dent's Usual Occu	ination			16h King	d of Business/In	dustry
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21	filed withi Hyglene. Ither than	E O	10	College (1-401 3+)	Tì	ruck Dri	ver			S.H	. Tevis	& Son
p	should be filed within 72 ho Id Mental Hyglene. marked other than "natu matic event, it e Medical	Be (17. Father's Name (First, Middle, Last)						First, Middle,		iumame)	
yla		၉	Truman Sauble				Marg	garet	Lynch			
Maryland	S S S		19a. Informant's Name/Relationship (Typ			ng Address (Stree				•		Code)
	1 and Healt em 2 ther	1 3	Judy Waters/daught 20a. Method of Disposition	er	2 Vi 20b. Place of Dispo	ictoria (Ct. Re:	ister Dat			21136 ation - City or To	State
nor	o to L	1	1X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crem Leisters	natory`or other pla					tminste	
Baltimore,		. 2	 4 □ Donation 5 □ Other (Specify) 21. Signature Fundal Service Ligense 	9 /)	'							L, MD
Ba	permit. Departn Imports any inju		Mulabo	elso, Dia		itts fu L2 Washi						21157
	1		23a. Parel. Enter the disease, or complice shock, or heart failure. List only on	ations that caused it	ne death. Do not ent	er the mode of dy	ing, such as c	cardiac or r	espiratory arr	est,	T P IND	21157 Approximate
	Physician [*]		Immediate Cause (Final disease or condition		RDIOVAS			150				Interval Between Onset and Death
	/Medical		resulting in death)		consequence of):		1	,,,,,	7 7 0			
	Examiner		S quentially list conditions b.		onges n'	LE IRE	mrT	FAI	LUKE	7		
	sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):		1				1	
	and and II-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):	ensin	<i></i>					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	dicai E										
687	ificate g phys	ab i	a.									_
Вох	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of		3er				23	d. Date of delive	ery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at tir		Ectopic pregnand Other (specify) _	су				Month	Day Year
P.0	at the de by the stached	Physician/M	9 Unknown	9 Unknown					T			
	res tha igned be del	by	Part II. Other significant conditions cont	nibuting to death but								ne cause of death?
orc	w require been sig should b	eted	DIABLES ME	mins.	MRS	A INT	2010	V_1	1 🗆 Y	es 2 🗹	No 3 Prob	ably 4 Unknown
Records,	e law has b	Completed	HOWMMAN L	WER EN	VRYME			_	24a. Was a autops	y	prior to cor	psy findings available mpletion of cause of
alF									perform 1 Yes	No No	death? 1 ☐ Yes	2 □ No
Vital		o Be	25. Was case referred to medical examiner?	ospital:	-55				Check on on			
of	Phys	\vdash	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	1 3 DOA	4 INUI:		 5 ☐ Resident Describe ho 		Other (Specifi	y)
lon	Attending Phyrdeath. ector; After thi	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	/ear) Injury	Wo	ork?]Yes 2.⊟N			,,		
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	/ - At home, farm, stre (Specify)	eet, factory, office		28	Location (SI	reet and	Number or Rura	il Route Number,
Ö	tal or A rs after al Direct ed in by	Cert	TO MONOGO	building, etc.	(Spacity)				City or Town	i, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examin	cian: To the best of e	my knowledge, death	occurred at the t	ime, date and	l place, and	d due to the ca	ause(s) a	nd manner as st	lated,
	To the h within 24 To the F complete	Medi	one)	and manner state	d.							
			29b. Signature and title of certifier	0 00		1	se number 0057e 7	7 1	2	- 2	signed (Month,	
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	10	- 1	30. Name an Vaddress of person who cor Johnson Dellofa, M		th (Item 23a) (Type, I • Luke Cir		stminst	ter, 1	MD 21	158		
	Sta	tė	31. Date filed (Month, Day, Year)	32. Registrar	s Signature							
	Registr		FEB 1 8 2	005 See	va S.	Corette ,						

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State of Maryland / Department of Health and Mental Hygiene

				State of Marylan	d / Depa	artment of H	lealth and	Mental Hy	giene	
			- State Ragistrar Amended #7	per FH:FCHD	TM 62	rtifigateogf i	Death		Reg. No. 0 0 5	07552
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	
	/Medic		Dennis		Se	well Sr.		Februa	7	
4	Examin	er	4a. Facility Name (If not institution, give st Frederick Memoria			4b. City, Town, or Freder	r Location of Deat	h	4c. County of Dea	
	E		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt	Freder	
	Funeral Director			M 2 F 84	Yrs.	Months Days	Hours Min.	8. Date of Birt	2 1910	rthplace (State or Foreign ountry)
	P .		Usual Residence of Decedent						,,,,,	
	shov	5	10a. State 10b. County FREDER	/	7, Town or Lo DENE	/				10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	the M	Director	10e. Street and Number	100 Pro	EDC1	10f. Zip Code			10g. Citizen of What C	
	with Sa or			SAINTS S	7.	2171	71		U. 5.4	ountry?
	death	Funeral	110000	2, Was Decedent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	,	
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puer Specify:	to Hican, etc.)	0	ite, etc.
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		105 202110	Spacity.		Specify:	LACK
21215-0036	be filed within 72 hours after death with the Manyland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Eramiran must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Business	s/Industry
12	filed withi Hygiene. other than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	-		SARD		FREDERICK	Cute School
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<u>la</u>		ToB	OGLE LESTER	SEWELL			MARG	URITE	BROWN	/
Maryland	and and sm		19a. Inf Jant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Number or R	Iral Route Numbe	er, City or Town, State,	Zip Code)
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altimore,	it. Pa rtmer rtant nlury		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cense			EWCENT 2. Name and Addres	or of English	18,2005	FRED. 1	WERRE HOME
B	permit. Pages 1 Department of H Important: if ite any injury or ot		Day T. Koll	el.		C	ith ST.		Md. 2176	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death			,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0	- 1/2					Onset and Death
	/Medical		resulting in death) a.	Due to (or as a consequence						2
	Examiner	_	Sequentially list conditions, b.	Emphison						Syca
	ted	nlne	cause. Enter Underlying Cause (Disease or injury	Due to or as consequ	Jence or):					
<u>,</u>	execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					
8760	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d.							
9	ntifica ng ph s as th	Physiclan/Medical	IF FEMALE:							
Вох	eath certifi attending	lan/	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 	death 3	Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
0	he de r the a	ysic	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)				,
<u>α</u>	that the de led by the detached		Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Records,	aw requires to been so	plet	alzheimers Di	sease	,			24a. Was		utopsy findings available completion of cause of
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Vital	nysician: Th nis certificate director, pag	Be (25. s case referred to medical examiner?		<u></u>		UES. Place of De	(Check only o		
of \	S S ID	2	1 ☐ Yes 2 No	- / -	ER/Outpatie		4 🗀 Nursing r		dence 6 Other (Sp.	ecify)
	fter fter	lon	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe i	now injury occurred	
Division	il or Attending after death. Director: After d in by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, st		100 2010	28f. Location (5	Street and Number or F	Rural Route Number,
S	ai or / s after ii Dire	Certification:	4 Homicide determined	building, etc. (Specif)	/)	,		City or Tox	vn, State)	
	hours hours uners ily fille		29a. Certifier (Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examina	wledge, deat	h occurred at the tin	ne, date and place	e, and due to the	cause(s) and manner a	is stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	and manner stated.	and and of it					
	To To	<	29b. Signature and title of certifier		,	29c. Licens			29d. Date signed (Mor	-
,	6		30. Name and address of person who cor	rull No	23a) /T	Print)	60 43		×11410	>
	.)		65 C Thomas	S JOHOVSE		OR FA	REDERI	CK p	2/14/00 DP 2170	2
	Sta	ite	31. Date filed (Month, Day, Year) 20	5 32. agistrar's Signa	1000	met .	·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 18, ALICE DOLORES SHUGART 11:30 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 13457 POPLAR HILL ROAD WALDORF CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV . 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) 87 Yrs. 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months 213-54-9187 Yrs. Director 1917 WASHINGTON DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other traumatic event, If w.M.c.J.c.d. Ever ritret must be retilled at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13457 POPLAR HILL ROAD 20601 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□ Yes 2X No Specify: Specify. 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR PONY FARM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE SAMUEL BROWN MARY IRMA HARDY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY I. STETLER - DAUGHTER 13457 POPLAR HILL RD., WALDORF, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery | 02-24-2005 Suitland, Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral Service P.O.BOX 156 22. Name and Address of Facility raun 1900053 HUNTT FUNERAL HOME WALDORF, MARYLAND 20604 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBRO VASCULAR Accipent disease or condition resulting in death) Hevas /Medical Due to (or as a consequence of): Examiner HYPERTENGON Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed3 2 No 2 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other 4 Nursing Home 5 Aesidence 6 Other (Specify) 7 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Mann of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident filled in by the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0418/05 P53552 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ARNEL EXTRANCE

FEB 2 2 2005

31. Date filed (Month, Day, Year)

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Walden

20602

12020 OLDLINECENTER

32. Recentrar's Signature

Piease Type or Print in Biack indelible Ink. Assure Aii Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month Year **Physician** Samuel Thomas Smith Feb 20:50 2005 18 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner University of Maryland Hospital Baltimore If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□F 219-34-4509 Aug. 11,1938 Pennsylvania Director Usuel Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other than "natural", or flema 23a or 28a-f show other than "natural", or flema 23a or 28a-f show other, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Cecil Port Deposit 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 87 Waterwheel Drive 21904 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ⊠Yes 2 □ No If Yes, Give Yeer or Dates: 1957 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Bethlehem Steel College (1-4or 5+) Two Years Elementary/Secondary (0-12) Baltimore, Maryland Mechanic 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health end Mentel Hy Important: if Item 27 is marked oth any Injury or other traumatic event page. 17. Father's Neme (First, Middle, Last) Helen Silverthorn Samuel Thomas Smith, Sr. 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Euna G. Smith (wife) 87 Waterwheel Drive, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State R.A. Ferris & Co., Inc. 2/20/05 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Money I. Takenson 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final 10 minutes Cardiae arrythomias disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner heart disease 5425 dypenionsine Hospital or Attending Physician: The law requires that the daath certificete be executed the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): and P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No cate has been signed by pega 2 should be detac reciline, Chronic obsmethe Luny Division of Vital Records, ģ decilue ventilator depondar 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed chronic menel failure, Dichelo mellihus 2 🗗 No 1 ☐ Yes 2 ₺ No 1 ☐ Yes 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Menper of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: A complataly filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 | Homicide 112 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as steted.
2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2/20/2005 D30494 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

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State Registrar FEB 2 2 2005

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32. Registrer's figurature

		1 - For State Registrar	State of	Marylar	nd / Depa <i>Ce</i>	artmen <i>rtificat</i>	it of H <i>e of L</i>	ealth a D <i>eath</i>	ind Ment	al Hygie	2000	0766
Physici /Medic			hlia Ella						M	te of Death	Day Yea	// Y
Examin	er	4a. Facility Name (If not institution, g 25 Wyatt L	ane				(Location of	f Death		4c. County of De	
Funeral Director		5. Social Security Number 6. 218-70-4288 Usual Residence of Decedent	Sex 7 1 □ M 2 🔀 F	. Age (In yrs. 97	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min. (M	te of Birth onth, Day, Ye ot 15	9. B 1907	irthplace (State or Foreig Country) Virginia
Be-f ahow	ctor	10a. State 10b. County Maryland Ce	cil	10c. Ci	ty, Town or Lo	cation	F	erryv	ille			10d. Inside City Limit
23a or 2 ust be no	Funeral Director	10e. Street and Number 1700 Perryville	Road			10f. Zip	Code	2190	3	10g.	Citizen of What C	•
- 3	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? ΓΣΝο	I	Vas Deced Yes, spec			in? (Specify Ye Puerto Rican,	es or No- etc.)	14. Race - Am Black, Wh Specify: W	
than the Man	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) Seven Years	ducation rade completed) College (1-4	or 5+)	16a. Deced (Give life. L	kind of wor OO NOT us	k done di e retired)	uring most	of working		Kind of Busines	•
othe	To Be Co	17. Father's Name (First, Middle, Las	U. Under	wood		ноп	nemak		s Name (First,	Middle, Maid	en Sumame)	Residence
alth and h		19a. Informant's Name/Relationship Thomas F. Schoff								Number, City	ckerson or Town, State, 21917	Zip Code)
Department of Health and Menta Importent: If Item 27 is marked any Injury or other treumatic eagus.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci	Removal from Stafy)		lace of Disposemetery, crem Mark	ition (Name atory or oth	e of her place	}	Date 2/25/0!	20c.	Location - City or	rTown, State e, Maryland
Depart import any inj once.		21. Signature of Funeral Service Lice	Editor	w. 5	Le Le Pe	Name and e A. rrvvi	Address Patt	of Facility erson Mary	land :	Funera	al Home,	
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page 2	TEO -	25. Was case referred to medical							-	Was an autopsy performed? Yes 2/10 No	prior to death?	topsy findings available completion of cause of
this ald	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			R/Outpatient 28b. Time of Injury	3☐ DOA 28c	Other: Injury at Work?	4 🗌 Nursir	Death (Checking Home 5 28d. Des		6 A Other (Specify occurred	sor share
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100 CO		19b. Signature and title of certifier A Harmon,	77				icense ni				ruury 2	, Day, Year)
	3	0. Name and address of person who o	FASD NS	death (Item 2	23a) (Type, Pri	nt)		1. 11		1/1+		

			1 - For State Registrar 1. Decedent's Name (First, Midd)		State of I	Marylar	-	artment of rtificate of			Mental Hygi	ene	05	07556
	Physici		MARGARET		ZABETH			SWEET			Month FEBRUARY	Day 10	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution					4b. City, Town,	, or Location	of Death	FEDRUARI		ty of Death	
			MILLENIUM HEAT	TH A	ND REH	AB CEI	TER		T. WAS				INCE	GEORGES
	Funeral Director		5. Social Security Number 577 22 5351 Usual Residence of Decedent	6. Sex 1 ☐ M	7.	Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day, FEB. 03,	1922	1 601	iplace (State or Foreign Intry) HINGTON, DC
	nyland thow		10a. State 10b. County			10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Ba-f s	Funeral Director	DC			V	VASHING	TON						XX Yes 2 No
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ထ္	hours after death with the Maryland turel', or Itams 23e or 28e-f show at Examiner is ust be notified at		1 ☐ Never Married 2 ☐ Mar		Armed Force 1 Yes X If Yes, Give	s?					ecify Yes or No- Rican, etc.)	В	lack, White	, etc.
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Maryland 2	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relations		, Print)		1				al Route Number,			ip Code)
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altimore,	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service		0 00	IIMI					HOME OF			
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8760,	Examiner physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Extra or berning Cause (Disease or injury that initiated events resulting in death) Last	b c d	Due to (or	TES M as a consec as a consec		3						
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ري ح	es that igned b be deta	by PI	Part II. Other significant condition	ons contri	buting to deat	h but not res	sulting in the u	nderlying cause o	given in Part	l.	23e. Did toba	cco use co	ntribute to	the cause of death?
īd	aquira en sig ould b		CHRONIC PANCR	EATIT	IS, HY	POTHY	ROIDIS	1			1 ☐ Yes	XX No	3 ☐ Pro	bably 4 🗆 Unknown
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Division of	ding Pt n. After th funeral	\vdash	1 Yes XXNo 27. Manner of Death XXNatural 5 Pendin 2 Accident invest	ng	1 ☐ Inp 28a. Date of l (Month,	-	28b. Time o Injury	f 28c. Inj	jury at /ork? □ Yes 2 □		me 5 Residen 28d. Describe how	ce 6 □C rinjury occ	ther <i>(Speci</i> urred	rfy)
Divis	afte in Direction	Certification:	3 Suicide 6 Could 4 Homicide determ	not be nined	28e. Place of building	Injury - At h , etc. <i>(Speci</i>	ome, farm, str fy)	reet, factory, offic	e		28f. Location (Stre City or Town,		mber or Rur	ral Route Number,
	To the Hospitel within 24 hours of To the Funerel completely filled	Medical	(Check only 2 Medical one)	Examine	ian: To the be r: On the basi and manner	s of examina	owledge, deat ation and/or in	vestigation, in my	opinion, de	nd place, ath occur	and due to the cau	e and place	e, and due t	to the cause(s)
	or co	Σ	29b. Signature and title of certific	_ 1	~				nse number					, Day, Year)
)	(6)		30 Name and address of parties	8cqu	-/-2	of death /li-	n 23a\ /T		8158			FEBRU	ARY 2	1, 2005
	0		30. Name and address of person SISOM OSIA, M.	_	Pieren canze			ILL RD.	SUITE	#500	OXON H	ILL,	MD 20	745
	Sta		31. Date filed (Month, Day, Year,		32. Reg	istrar's Sign:		ti.						
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		ı	For State Registrar	Please	State of Ma		Depart		lealth and	Mental Hyg	-) 0 5	07557
			Decedent's Name	(First, Middle, Last	")					2. Date of Deat	th		3. Time of Death
	Physici /Medic		CLAUDE A	A. SMITH						Februa:	ry 15,	2005	12:42 a ^M
	Examin		4a. Facility Name (If	not institution, give	street and number)		4	b. City, Town, o	or Location of Dea	th	4c. Count	ty of Death	
w				th Avenue		//		Hyattsv If Under 1 Year		0.0		ce Ge	orge's
	Funeral Director		5. Social Security Nu 213-38-48	4.7	X / /.Age XM 2□F	9 (In yrs. last bii 92		Months Days	Hours Min		Year)		place (State or Foreign ntry) iana
42			Usual Residence of			72				Jair. Ju	, 1713	1110	Lana
	nylan ihow	_	10a. State	10b. County		10c. City, Tow	m or Local	tion					10d. Inside City Limits
	Ba-f.s	Director	Maryland	Prince G	eorge's	Hyatt	svill	Le					1 X Yes 2 □ No
	vith th		10e. Street and Num					10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
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Ž	s 1 and 2 should be f Health and Mental h item 27 is marked of other traumatic eve	To	Audrey I		ype, Print)	198	o. Mailing	Address (Street		. Hummon	. City or Town	n. State. Zii	o Code)
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Ē	Page nent c ant: #				Removal from State			n Cremat	J	7/2005	Alexan	dria,	Virginia
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra		21. Signature of Fur	neral Service Licen	//		22. N	lame and Addre	ss of Facility G	asch's Fu			
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)	Physician /Medical	60.	23a. Part1. Enter the shock or hear Immediate Cause (I disease or condition resulting in death)	t failure. List only d Final	lications that caused one cause on each lin	10.							Approximate Interval Between Onset and Death
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9 X	feath certificate attending physi	/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy					224 D	ate of deliv	
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۵,	res that signed b	by PI	Part II. Other signifi	A	ntributing to death bu	-	in the unde	erlying cause giv	ven in Part I.				he cause of death?
rds	w require been sig should b		Blad	lder 1	Carice	R				1 □ Ye	s 2 No	3 🗍 Prol	bably 4 Unknown
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of \	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ 1	10		nt 2 ER/O		3L DOA		Home 5 Reside		- ' '	fy)
Division (ding h. After fune	atlon;	27. Manner of Death 1 ☑Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injur (Month, Day		Time of Injury	M 1	ry at rk? Yes 2 □ No	28d. Describe ho	w injury occu	ırred	
Divis	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, fa c. (Specify)	arm, street	t, factory, office		28f. Location (St City or Town		nber or Run	al Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)	1⊠ Certifying Phy 2☐ Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination ar	e, death or nd/or inves	ccurred at the tistigation, in my o	me, date and place opinion, death occ	e, and due to the caurred at the time, d	ause(s) and mate and place	nanner as s , and due t	stated. o the cause(s)
)	To th	M	29b. Signature and	title of certifier	en Oel completed cause of do	2me S	2	29c. Licens	se number	Z /	9d. Date sign Tebul	ed (Month,	Day, Year)
21	12)10	1	30. Name and addre	ess of person who c	ompleted cause of de	eath (Item 23a)	(Type, Pri	nt)	RI	hatts	ille M	4 2	272/
Ş	Sta		31. Date filed (Monti	h, Day, Year) 2 2 2005	2. Registra	ur's Signature	had	23 5000		771430	FF. F & "	-3 -(701
	Registr	ar	250	(),	A WARRAGE	AT A	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 2-22-05 Amend# 23a.Prt.l.Per Phys.Pertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician FEBRUARY 04, 2005 ANNIE MAE SIMMONS 4:40A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Months Days Hours Min. Yrs. Director 255 86 5104 GEORGIA Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at XX Yes 2 No Director MARYLAND MONTGOMERY TAKOMA PARK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Itams 23a 7525 CARROLL AVENUE 20912 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes XX No Specify: Specify: BLACK XX Widowed 4 □ Divorced natural traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6TH HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Part: If Item 27 Is marked of ပ CLYDE PEAVY ELLA KINCHON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLA SIMMONS WHITE / DAUGHTER 1832 METZEROTT RD. #B4 ADELPHI, MD 20783 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XIX Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. PINEVIEW CEMETERY 02/13/2005 MORVEN, GA 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each [16], Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as youns **Examiner** ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the buriat-transi Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other Significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 DUnknown 1 Yes 2 No 3 Probably page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of leath?

1 Yes 2 No 1 ☐ Yes 2 N Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of 28b. Time of 28d. Describe how injury occurred Injury 1 University 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) within 2 To the 29b. Signature 30. Name and oddress of person who completed cause of death illumination 23a) (Type, Print) 209/2

Registrar

DHMH 17 Rev 1/2001

State

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FEB 2 2 2005

31. Date filed (Month, Day, Year)

ARROLL

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Physicia /Medica		1. Decedent's Name (First, Middle, L Jude Sanfo	,				2. Date of De Month Februa	Day	3 Time of beam 2005 12:27 P M
Examine Funeral		4a. Facility Name (If not institution, g. Prince George's 5. Social Security Number 6.	Hospital C	enter e (In yrs. last birthday)	4b. City, Town, or Cheve		Hrs. 8. Date of Bir	th	ce George's
Director		578-84-3293 Usual Residence of Decedent 10a. State 10b. County	1MM 2□F	45 Yrs.	Months Days	Hours	Mar. 17	y, Year)	Birthplace (State or Foreign Country) Alabama
ours after death with the Maryland rail, or Hems 23s or 28s-f show	ector	DC 10e. Street and Number		Washingt				10g. Citizen of V	10d. Inside City Limits 1 X Yes 2 □ No
death with ms 23a or	Funeral Director	4121 Massachuett	12. Was Decedent		2001		? (Specify Yes or No uerto Rican, etc.)	1	USA e - American Indian,
<u> </u>	þ	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	f Yes, specify Cubar 1 □ Yes 2∑ No	Specify:	uerto Rican, etc.)	Blac Specify	ck, White, etc. Black
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Vial y fall of L.	To Be C	17. Father's Name (First, Middle, La: Jude Sanford, Sr	*				Name (First, Middle M. James	L	
		19a. Informant's Name/Relationship Eva Sanford/Moth		412	21 Massach	nuettes		Washing	ton,DC 20019
parmit. Pages 1 ar permit. Pages 1 ar Department of Hem Important: if item any injury or othe once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec	sify)	Harmony	Memorial	2/	Date /25/05	Lando	City or Town, State
Depariment of the policy of th	23a. Part 1. Enter the disease; or complications that caused the death. Do not enter the mode of dying, such as cardiac or resi							orings, 1	
Pnysician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each li a. Intrapa	renchymal b					Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Lister by userlying Cause (Disease or injury	b	a consequence of):					
par par	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of);					
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w requires that been signed be should be deta	þ	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause give	n in Part I.	23e. Did 1		ribute to the cause of death? 3 □ Probably 4 Unknown
Tha law ate has be page 2 sl	Completed						24a. Was auto perfo	an 24b.1 psy prmed? 2 \(\text{No} \)	Were autopsy findings available prior to completion of cause of death? 1
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2 6	Me	29b. Signature and title of certifier	M. X.	one &.	29c. License	number CME		-	d (Month, Day, Year)
y C		THE more	Liking	de Ttem 23a) (Type,	Print) 111 Pe	nn Str			Maryland 21201
Sta Registra		31. Date filed (Month, Day, Year) MAR 0 1 2005	Car. Registr	rar's Signature					

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	/Medic Examir		4a. Facility Name (If not institution	RANDALI n, give street and number		4b. City, Town,	or Location of Death	Feb. 2	4c. County of De	9:00 A ^M
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	Funeral Director		5. Social Security Number 219–03–7780	6. Sex 7. Aq 1 M 2 ☐ F	ge (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 9/18/1	9. B 1915 Pe:	irthplace (State or Foreign Country) nnsylvania
	and		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or Lo	cation				10d. Inside City Limits
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	or 282	lrec	10e. Street and Number			10f. Zip Code			0g. Citizen of What (Country?
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I've Medical Evantral natural be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	No	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ∰ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	. 14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
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Ž	2 should be and Mental Is marked o	P	19a. Informant's Name/Relation	ship (Type, Print)			Late	Mari	.a SCNI City or Town, State	nepfe ^{, Zip Code)} 21047
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imo	Page nent c ant: If ury or		1 Burial 2 Cremation 4 Donation 5 Other (3 ☐ Removal from State Specify)	Carroll	Cremat	ion 3/3	/2005 H	amustea	. Maryland
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Ö	tal or version at Direction bed in b	Certification:	4 Homicide	building, e	tc. (Specify)			City or Towr	n, State)	
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	To t To t	Σ	29b. Signature and title of certific	2 mg			15e number)	9d. Date signed (Mo. FB、28,	
	5		30. Name and address of person	pleted cause of	death (Item 23a) (Type,	Print) Local	Royal Bh	N SuiTE	08-A BAK.	2005 min=mo21220
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 14, 2005 7:30 P^{M} Irene Floyd True /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick College View Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Min. **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs 95 North Carolina June 4, 1909 Director 578-20-4870 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itams 23s or 28s-f show ury or other traumatic event, it a Medical Evaluation must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Frederick Monrovia Completed by Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 3934 Rosewood Road 21770 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify. 3XXWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Healthcare** Private Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Floyd Viola Cribb ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3934 Rosewood Rd. Monrovia, MD 21770 F. Ellen Noland / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 16, permit. Pages 1 Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2005 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) Resthaven Crematory 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature | Fun al Strvice Lice | e 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PHEU MOYIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No should be detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No to the Hospital or Attanding Physician: 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification; To hours after death.

Inaral Diractor: After this y filled in by the funeral di 28c. 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce ifie LUD) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature ORGSUM TOWN Plus - FREDERICL MO 2002 MEROCA MD

DHMH 17 Rev 1/2001

State Registrar

2005

			State of Mary		Department of F Certificate of			glerie Reg. No. 2	105	0756
Physic		Decedent's Name (First, Middle, Last) JAMES	С.	TOLIVE	ER		2. Date of De Month FEBRUAL	Dey	Year 005	3. Time of Death.)
/Med Exami		4e Fecility Neme (If not institution, give s	treet and number)			4b. City, Town, or L	ocation of Deet	4c. County	of Death	
, Exam		LARKIN CHASE NURSI	NG HOME			BOWIE		PRINC		
Funera		5. Sociel Security Number 6. Sex	7. Age (III	n yrs. last bir	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthpla Countr	ice (State or Foreign
Director		436-18-7534	86		Yrs.		OCTOBER	15 191	d Lou:	isiana
pue 🗼		Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Tow	n or Location				10	d. Inside City Limits
Menyi 4 sho	ō	MD PRINCE GE	ORGE'S	BOWIE						1∭Yes 2□No
288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	hat Counti	ry?
3a o	<u></u>	3800 ENFIELD CHASE	COURT # 3	02	20716			U.S.A.		
death	Funeral		2. Was Decedent Eve Armed Forces?		13. Wes Decedent of I	Hispanic Origin? (Sp	ecify Yes or No	14. Race	e - America k, White, e	
72 hours after death with the Merylend natural', or Rema 23a or 28a-f show Gesi Examiner must be notified at		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	ARMY	1 ☐ Yes 2 No		, radan, didi,		BLAC	
	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cetion completed) College (1-4or 5+)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	petion during most of work d)	king	16b. Kind of Bu	siness/Indu	ustry
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2 sho end is m		19a. Informant's Name/Relationship (Ty)		19b	Meiling Address (Stree 00 Enfield	tand Number or Rui	rel Route Numb 北 302	er, City or Town, Bowie M	State, Zip (larv1a	code) and 20716
s 1 and if Health Item 27 other tr		Marie H. Toliver/	Vite				Date	20c. Location -		
Se to I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)	emoval from State		f Disposition (Name of ry, cremetory or other pla Walden Ceme	tery	2/26/05	Pfluger	dille	,Texas
permit. Pages Department of Important; If it any injury or o		21. Signature of Funeral Strvice Lice s	1 M	7	22. Name and Addre					
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Physician /Medical		shock, or hear failure. List only or Immediate Cause (Final disease or condition		vascu1	ar Accident					Onset and Death
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that the de led by the a deteched t		Renal Failure		-			1	Yes 28 No	3∐ Prob	ably 4 ☐ Unknow
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certificate h		25. Was case referred to medical				26. Place of Dea				
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ding Phys h. After this funerel d	-	27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Dey Y		Time of 28c. Injury			how injury occur		
I or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, fa	arm, street, factory, office)		(Street and Numb own, State)	er or Rura	Route Number,
Hospita 4 hours Funeral tely filled	edical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of n ner: On the basis of ex end manner stete	amination er	e, deeth occurred at the t nd/or investigation, in my	ime, date and place opinion, death occu	, and due to the rred et the time	cause(s) and ma , date and place,	anner as stand due to	ated. the cause(s)
within 2 To the	ĕ ∑	29b. Signature and title of certifier		146	29c. Licer	ise number		29d. Date signe	d (Month, I	Day, Year)
⊢≯⊢ŏ		1 Malak	15ev2in	91	D00)56986		Februar	v 22.	2005
10)	30. Name end eddress of person who co	empleted cause of deel	th (Item 23e)		,,,,,,,,,,		TODIUGI	, 44.5	2000
(10)	1	Chalak Berziniji				e 105 Gre	enbelt	, Maryla	nd 20	770
s	tate	31. Date filed (Month, Dey, Year)	2. Registrar's	Signature	•					
Regis		FFR 2 2 2005	Heading	K	mede					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yeer **Physician** bert 2005 26 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Adventist Mon ark Washington lacoma If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 1 578-52-7554 Director South Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other then "natural", or itema 23a or 28a-f show other traumatic event, the Medical Exertiner must be notified at 1 Yes 2 No DC Director ashington 10e. Street and Number 10f: Zip Code 10g. Citizen of What Country? USA ital Street, 0001 1200 North Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Slack þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Government permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Itam 27 is marked other the eny injury or other traumatic event, Itam 2018. Count an 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 2 homas unning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington Shirlmerka 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mem. 4 □Donation 5 □Other (Specify) TaHC Signature of Funeral Service Licensee

22. Name and Address of Facility

Ralph & Williams Funeral Service

16.1 18.13 Fotomac fue. S.E. Washi.

Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ediate Cause (Final) 21. Signature of Funeral Service Licensee Washington, 20003 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 Irag disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and resulting in death) Last sequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 10 1 Yes completely filled in by the funeral director, 25. Was case 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Anatural 5 Pending Injury death. investigation 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of bertitier o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 1/2001

State

Registrar

Registrar's Signature

2

		•	For State Registrar	State	of Marylar			ent of He ate of D		d Me	, ,	iene	200	5	07561
	hysicia		1. Decedent's Name (First, Middle, Lateral Deborah Tomp)	•							Date of Deat Month			ar	3. Time of Death 7:25 A M
	/Medic xamin		4a. Facility Name (If not institution, give		um <i>ber</i>)		4b. Ci	y, Town, or i	ocation of D		Cerrain	-	County of E		
			Doctors Comm	unity H	Hospital			Laı	nham				Pri	nce	George's
	neral ector		217-82-7015	ex □ M 2 X 1F	7. Age (In yrs.	. last birthday) 3 Yrs.	If Und Month		Hours N	Hrs. 8. Min. 0	Date of Birth (Month, Day, ct. 23	Year)	961	Count	ace (State or Foreign try) Sh., DC
and	-		Usual Residence of Decedent 10a, State 10b, County		10c. C	ity, Town or Lo	cation							10	Od. Inside City Limits
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th wit	ST ES	ai D	6607 - 24	th Ave	• •				2078	2			Unite	ed S	States
r dea	BLE E	Funerai	11. Marital Status	Armed F			Was De	edent of His	panic Origin' , Mexican, P	? (Specif	y Yes or No- can, etc.)		14. Race - / Black, V		
Defitimore, INIGINITIES ALSO-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	Evanir Evanir	þ	1 ☐ Never Mamed 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes If Yes, 0 Year or	: 2 □XNo Sive Dates:		1 ☐ Yes	2 X No	Specify:					B1 <i>a</i>	
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Viand build be fill Mental Hy	IC eve	To Be	Clyde To						io. Mothers		First, Middle, M Bessie			5	
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and 2 si ealth an	m 27.1		Bessie Tompkins	- Moth		-			Ave.,		ttsvil			2078	
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death death	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 Fet			pregnancy (s <i>pecify</i>)					Month		Day Year
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= E	IN B	ion:	27. Manner of Death ↑ SNatural 5 ☐ Pending	(Mo	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injury Work	at		d. Describe ho				
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UIVISION OI VITA To the Hospitel or Attending Physicien: within 24 hours after death.	completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nner: On the	ne best of my kno basis of examina inner stated.	owledge, death ation and/or inv	occurre vestigati	ed at the time on, in my opi	e, date and pl nion, death o	lace, and	d due to the ca at the time, da	use(s) ate and	and manne place, and	r as sta due to	ated. the cause(s)
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9			1 feun	Ru	ner				194	146		Febr	nary i	17.	2005
- 11	0/		30. Name and address of person who	completed ca	use of death (Ite				,				1		
	Sta	te	Steven Remsen M. 31. Date filed (Month, Day, Year)	ت کر خ .2.	Main Registrar's Sign	Street ature	5417	e 351	Laure	1 md	20107				
R	ەنە legistr		FEB 2 2 2005	The same	Registrar's Sign	han	R.								

DHMH 17 Rev 1/2001

Deborah A. TompKins

			For State Registrar	State of Ma	aryland /		rtment of F		l Mental Hy	gień Reg. N	- O O O	0	7565
	Diam'r.		1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath			Time of Death
	Physici /Medio		David Warre	n Timken					Februa	ry	25, 200	5 2	2222 м
	Examir		4a. Facility Name (If not institution, g.	ve street and number)			4b. City, Town, o	r Location of De	ath	4	lc. County of De	ath	
			Harford Memo: 5. Social Security Number 6.		al le (In yrs. last b	hirth day)	Havre of If Under 1 Year	de Grace		41-	Harfor		(0)
	Funeral Director		220-34-7425 Usual Residence of Decedent	1X M 2 F	64	Yrs.	Months Days	Hours Mi		V Yea	ma:	ry Lai	(State or Foreign
	yland now		10a. State 10b. County	-	10c. City, To	wn or Loc	ation					10d. li	nside City Limits
	e-fst	ctor	MD Harford	3	Perr	yman						1	☐ Yes 2X No
	or 28	Funeral Director	10e. Street and Number	-			10f. Zip Code			10g. C	Citizen of What (Country?	
	ath w 23e	ral	308 Irish La	ne			21130				U.S.A.		
	er de Items	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	14. Race - An Black, Wh		ndian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show early injury or other treumatic event, The Madical Examinar must be natified at anone.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1X Yes 2 ☐ If Yes, Give Year or Dates:	957-60		□Yes 2X No	Specify:		4	Specify: W	hite	
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Maryland	shou and N s mar		19a. Informant's Name/Relationship	(Type, Print)	15	9b. Mailin	g Address (Street		Rural Route Numb	er, City	or Town, State,	Zip Cod	e)
	and 2 saith a n 27 i		Patricia T. Ke	eton (Daugh	nter)	308	Irish :	Lane :	Perryma	n,	MD 21	130	
Baltimore,	of He		20a. Method of Disposition ★★Burial 2 ☐ Cremation 3	Removal from State	cemet	tery, crem	sition (Name of natory or other place	00)	Date		Location - City of		_
Ĕ	Pag ment ent: I		`4 □Donation 5 □Other (Spec		Spesu	tia (Cemetery	3/1	/05	Pe	rryman,	Mar	yLand
3all	Depart Depart Import eny in		21. Signature of Funeral Service	ensee	1.	22.	Name and Addre	ss of Facility -Cargo E	uneral H	ome	, P.A.		
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ı,	Examiner		Immediate Cause (Final disease or condition resulting in death) a. INTRA CRANIAL SUBBDING Due to (or as a consequence of): Sequentially list conditions b. GASTRO INTESTIMAL SUBBDING i										
	P #	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequenc		TYPL			1 2			
	outed id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	META	STAT	10	CANC	EST				4	MONTH
o,	an ar	EX	resulting in death) Last	Due to (or as	a consequenc	e of):							
38760,	cate be executed physician and the burial-transit	dical	•	d								-	
_			IF FEMALE:	220 If yes outcome	of prognancy								
P.O. Box	atten for us	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)	,			23d. Date of d Month	elivery Day	Year
o.	the de y the iched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	tane or death	3	Other (specify)						
	that ned b deta	y Pt	Part II. Other significant conditions	contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.	23e. Did 1	obacco	use contribute	to the ca	use of death?
rds	quires n sigr	d b	COAGULOGATH	1, THROM	BOCY	TOP	ENIA		10	Yes .	2 □ No 3 □ F	robably	4 Unknown
00	aw require s been sig 2 should b	Completed by	/	,					24a. Was		24b. Were	autopsy fi	indings available
R	The la	Шо	1						auto perfo	psy rmed?	death?	,	ion of cause of
ta	ien: rtifica stor, p	O	25. Was case referred to medical					26. Place of D	eath (Check only	· · ·	10 1016	13 2/2	140
<u>></u>	nysic nis ce I direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/C	Dutpatient	3□ DOA Cth	er: 4 Nursing	Home 5 ☐ Resi	dence	6 □Other (Sp	ecify)	
O L	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	28c. Injur Wor		28d. Describe	how inj	ury occurred		
Division of Vital Records,	tendi leath. tor: A the fu	Certification:	2 Accident investigate 3 Suicide 6 Could not	he -		-		Yes 2 No					
<u>></u>	lor At after o Direct Lin by	ititi	4 Homicide determine		ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (City or To		and Number or F ite)	Rural Rot	ite Number,
_	pitel ours a erel (29a. Certifier 1XI Certifying F	hyeicien: To the hest	of my knowled	an doath	coourned at the time	no data and ala	on, and due to the		(a) and manner.		
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medical Exe	hysicien: To the best miner: On the basis o and manner st	f examination a	and/or inv	estigation, in my o	pinion, death oc	ce, and due to the curred at the time,	date a	s) and manner and place, and di	ue to the	cause(s)
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director. After this certificate has been signed by the attending to the Funerel Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Me	29b. Signature and title of certifier	A . O			29c. License	e number		29d. D	ate signed (Moi	nth, Day,	Year)
	- > - 0		JOSharing	_ MD.			D3	1856		0;	2/25/5	100	5
	axl		30. Name and address of person who	completed cause of d	leath (Item 23a	l) (Type, F	rigt) 4 10	V. BIZ	40 10	0 9	Project		
			30. Name and address of person who DESH SHARMA	M) 602 5	SOHICUT	DOD	KI) AT IC	o osel	ALIA PUR		7 - 7 - 7		
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Di ii	Registr	ar	ment o 1 5	100 John	U K	A	all o						
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TIMKIN, DAVO

			For State Registrar		State of N	Marylan		artment rtificate					Reg. No.	2005) (756	56
	Physici		1. Decedent's Name (First	st, Middle, Last)	1/	10/ 1.					Date of De Month	ath Day	Year		Time of Deat	
	/Medic	al	zinoviy				ulitski,			Ition -	4.0	Fe6	14	2009		1:40 A	М
	Examin	ÇI	4a. Facility Name (If not in Shady Grove	-				Rock		Location o	r Death			County of Dea ntgome			
	Funeral		5. Social Security Number	er 6. Se	x 7.		last birthday)	If Under	1 Year	If Under 2		8. Date of Bir (Month, Da				(State or Fore	aign
	Director		294-92-1198 Usual Residence of Dece		ŬM 2□F	80	Yrs.	Months	Days	Hours	Min.	07/12/1	y, 76ar) L924	Uk	rain	e	
	land ow			. County		10c. Cit	y, Town or Lo	cation							10d. In	nside City Lim	nits
	Mary I sh	ţō	MD M	ontgome	ry	Roc	kville								1	□Yes 2¶	No
	or 282	ire	10e. Street and Number					10f. Zip	Code				10g. Citiz	en of What Co	ountry?		
	ath wi	ral	6121 Montr	ose Roa				208					U.S.				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Itams 23e or 28e-f show empty injury or other treumatic event, the Medical Examinational Le multiput at ODGE.	by Fur	11. Marital Status 1 Never Married 3 Widowed 4 1		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	ş? ∑No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: Wh	te, etc.	dian,	
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7	ited w tygier ther th	Co	17. Father's Name (First,	Middle (ast)	5+		Econo	mist		18 Mothe	r's Name	(First, Middle		ersity			
anc	d be findal hed ot) Be	Aron Vulit									nkova	Walder .	ourrame)			
Maryland	should Me mark matic	2	19a. Informant's Name/F		ype, Print)		19b. Mailir	ng Address	(Street a				er, City or	Town, State,	Zip Code	э)	
N S	nd 2 aith ar 27 is 27 is ir freu		Mark Vulit	sky, So	n		901 N	orth l	Monr	oe St	. #9	13, Ar	lingt	on, Vi	rgin	ia 222	201
Baltimore,	item		20a. Method of Disposition	on		20b. F	Place of Dispo	sition (Nam	e of her place	9)	Da	ate	20c. Loc	ation - City or	Town, S	State	
Ē	Page Inent of Inch of	- 1	1 □ Burial 2 🛛 Cre `4 □ Donation 5 □			te l					2/18	/2005	Brent	wood,	Mary	yland	
alt	ppartr pporte ny inju		21. Signature of Funeral	Service Licens	999	1		. Name and			~	mple T					
_	80 E 9 8		- Dul	my e	an W.	ul_								, Mary			
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68760,	ate be executed hysician and the burial-transit	icai			d												
Box 68	v requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No	ths?	23c. If yes, outcor 1□Live birth 4□Pregnan	2 ☐ Feta t at time of c	Ideath 3	Ectopic pre					2	3d. Date of de Month	livery Day	Year	
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Records,	e lav has je 2	Completed							·			24a. Was auto perfo		24b. Were a prior to death?	completi	ion of cause	ble of
Vital	ysicien: Th is certificate director, pag	Be (25. Was case referred to examiner?	-							of Death	(Check only					
of		2	1 ☐ Yes 2 ☑ No 27. Manner ol Death		Hospital: 1 ∠Inpa	njury	ER/Outpatier 28b. Time o		A Othe 8c. Injury Work	4 🗆 Nu		ne 5 Resi 8d. Describe		Other (Spe	ecify)		
ion	Attending Ir death. ector: After by the fune	atio	2 Accident	 Pending investigation 	(MOTHE),	Day Year)	Injury	М		r res 2 🗆 t	No						
Division	al or Atte	ertification:	3 Suicide 6 [4 Homicide	Could not be determined	28e. Place of building,	Injury - At he etc. (Specif	ome, farm, sti	eet, lactory	, office		2	8f. Location (City or To		Number or R	ural Rou	ite Number,	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier 1 ∠ (Check only one) 2 □	Certifying Phy Medical Exam	sician: To the be iner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date an	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and du	s stated. e to the o	cause(s)	
	To th withir To th comp	Me	29b. Signature and title	1	A					number				signed (Mon	th. Day,	Year)	
)			Christne	e Loy	pont		717		D 6	15	4 9		Fe 6	/	4	200	5
	1		30. Name and address of Christine	/	porte 99	01 Me	dical (Centei	r Dr	ive,	Rocky	ville,	Mary	land 2	0850		
	Sta Registi		31. Date filed (Month, De	av. Year)	The State of the S	istrar's Signa	ature spa	de									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 20 Month Physician February 2005 3:35 P M Vann Julia /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Larkin Chase Nursing Home Bowie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, May 21 Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 1 F 1914 North Carolina 153-16-0923 90 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28e-f show 1- Yes 2 No Director Prince George's Upper Marlboro 10e. Street and Number 10g, Citizen of What Country? 20772 U.S.A. 3612 Eyre Drive South Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 22亿 No Specify: Specify þ 3 ∰ Widowed 4 ☐ Divorced Black "natural" Completed of Health and Mental Hygiene.
Item 27 is marked other than "nature other traumatic event, it is Medical. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: if Item 27 is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hattie Gavin Luke Gavin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Robinson/Daughter 3612 Eyre Drive South Marlboro Maryland 20772 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/05 Turkey, North Carolina 5 Other (Specify) Family Plot 4 Donation 21. Signature of Fundal 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. I complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediale Cause (Final Atherosclerosis Heart Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed Atrial Fibrillation as the burial-tran attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 1 Yes 2₺ No or Attending Physicien: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 3 DOA 10 2 ER/Outpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28c. Injury at Work? Certification: After 1 2 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death d in by the f 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a To the Funerat L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ak 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora M.D. 14300 Gallant Fox Lane Suite 222 Bowie, Maryland 20715 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 2 2 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Dorothy Louise Williams 18 2005 11:28 A February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Citizens Nursing Home Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 89 230-10-9142 Director Nov 30 1915 Loudoun Co VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Evandras must be notified at 1 ☐ Yes 21 No Lovettsville VA Loudoun Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20180 USA 13233 Orrison Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 → No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lacy Pauline Mann Luther Paul Tritapoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5519 Gapland Road, Jefferson, MD Phyllis Jane Lewis, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State pernit. Pages 1 Department of F Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation / 5 ☐ Other (Specify) 2/22/2005 Union Cemetery Leesburg, VA 21. Sign fure of runeral Service Licensee

Barvara A. Will: 22. Name and Address of Facility John T. Williams Funeral Home Williams, owner 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cerebro VASCUla, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examine Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 → Yeo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2: autopsy performed? 212 No 10 . Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No Certification: To 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. The law requires that the death certificate be P.O. Division of Vital Records. Hospital or Attending 28a-f show

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itema 23a

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the attending physician

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After this

Director:

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(Check only one)

29b. Signature and the of certifier

29a. Certifier

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

and manner stated.

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2005

who completed cause of death (tem 23a) (Type, 801 egistrar's Signature

f 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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			1 - For State Registrar Amend Item			rtment of Health		Hygie Reg.	21105	07560)
	Physicia		1. Decedent's Name (First, Middle, La:	FRANCES ELI			2. Date o Month Febru	f Death	Day Year 21, 2005	3. Time of Death 9:08 P	1
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Location			4c. County of Death		
			Citizens Nursing 5. Social Security Number 6. S		(In yrs. last birthday)	Frederick If Under 1 Year If Und	ter 24 Hrs. 8. Date o	f Righ	Frederi		
	Funeral Director			□ M 2 1 F	91 Yrs.	Months Days Hours	s Min. Sept	, Day, Ye	1913 Ge	nplace (State or Foreign intry) Orgia	7
	pu l		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Loc	cation		30		10d. Inside City Limits	
	Maryla fahor	ro	Maryland Frederi		Frederic					1√2 Yes 2 □ No	
	or 28e	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	untry?	_
	ath wil	raic	1900 Rosemont Ave			21702			U.S.A.		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or liems 23a or 28e-f ahow other traumatic event. The Medical Examination at notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 1 No If Yes, Give Year or Dates:	If	Vas Decedent of Hispanic (Yes, specify Cuban, Mexic ☐ Yes 2 No Speci	can, Puerto Rican, etc.	r No-)	14. Race - Amer Black, White Specify: WI		
2-0	72 hou	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	ent's Usual Occupation kind of work done during m	nost of working	16b	b. Kind of Business/li	ndustry	
121	within ane. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	DO NOT use retired) Communicatio			NIH		
d 2	filed Hygie other ent,	Be Co	17. Father's Name (First, Middle, Last,				ther's Name (First, Mic	ddle, Maid			
/lan	ould be I Mental I arked o	To B	George Walter Mer	ritt		Wil	lie Lee Ja	mes			
Maryland 21215-0036	2 should and Men 1s marke raumatic		19a. Informant's Name/Relationship (g Address (Street and Nun					ď
	1 and 2 Health tem 27 l		Catherine Goebel 20a. Method of Disposition	(Sister)		Arbor Drive, sition (Name of patory or other place)	Prederick		ryland 21, c. Location - City or T		-
ē	Pages nent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif			g Crematory	2/23/05	Sm	ithsburg,	Maryland	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 2008.		21. Signature of Funeral Service er	Jailey 7	RO1	Name and Address of Fac BERT E. DAIL 01 NORTH MAR	cility EY & SON F	UNERA	AL HOMES.	P.A.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do not ente	er the mode of dying, such	as cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			scular	Stroke	_		1 WEEK	
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a	consequence of):						
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):						-
8760,	cate be executed ohysician and the burial-transit	dicai E		d	30,130,400,130,017.						
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O. Box	that the death certifii ed by the attending f detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□ Unknown	☐ Fetel death 3 ☐	Ectopic pregnancy Other (specify)		-	23d. Date of delive Month	very Day Year	
٥,	es that the igned by th be detache	by Ph	Part II. Other significant conditions of	contributing to death but	not resulting in the un	derlying cause given in Pa	rt I. 23e. I	Did tobace	co use contribute to	the cause of death?	
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Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	Other	ace of Death (Check of Nursing Home 5 F		o 6 DOthor (Care	24.1	-
J of	ig Phys ter this neral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury at Work?			injury occurred	ny)	
Sior	Attanding r death. sctor: After by the fune	catic	1 Natural 5 Pending investigation 3 Suicide 6 Could not be	n		M 1 ☐ Yes 2					
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	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License numbe	ər	29d.	Date signed (Month,	, Day, Year)	
	/			Shah tri	· · · · · · · · · · · · · · · · · · ·	D5164	13	0	2/22/05	5	
	5		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, I	Print)	0101-0	^^	10 1100	2-	
	Sta	te	31. Date filed (Month Day, Year), 2	005 32 degistrar	s Signatura	Section 1	CC 7045		· P AID		-
	Registr	ar	1 20 20 2		A Second						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** February 18 2005 15:30 Thelma Dorena Wise /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Gladys Spellman Nursing Center Cheverly
If Under 1 Year | If Under 24 Hrs. | Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2√2 F 76 577-32-9582 Yrs Director May 26, 1928 Wash. DC Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 TyYes 2 □ No Director Cheverly Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 United States 2900 Mercy Lane filed within 72 hours after death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21☐ No If Yes, Give 14. Race - American Indian, Black, White itean 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify American 3-√∑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nt of Health and Mental H
I: if item 27 is marked oth

or other traumatic sven 1 and 2 should be Sally Mae Smith ျှ James Henry Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 Donna D. Wise - Daughter 1117 Danbury Dr., Bowie, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Demoval from State permit. Page Department of Important: if any injury or 2/25/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD Harmony Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Leeta over Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat - cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2 🗆 No certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2 ER/Outpatient 3 DOA this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification; After Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hours after 4 Homicide Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 29d. Date signed (Month, Day, Year) 29b. Signature and title 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) NG MUR 31. Date filed (Month, Day, Year) State FEB 2 2 2005 Registrar

			State of Maryland / Department of Health and I = State Amend Item 23b,25,27,28a-f per me 1841 3-22-05 tas Registrer Certificate of Death	Mental Hygs	gien e () (Reg. No.)5	07571
*	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	D -	Year	3. Time of Death
	/Medic	al	ETHEL MARIE WORTHY	Februar	4 18	2005	1027 M
	Examin	er	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Peninsula Regional Medical Confer Sallsbuild	1	4c. County	of Death	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	h	9. Birthpl	lace (State or Foreign
	Director		263-67-348/ 1 M 2 F 39 Yrs. Months Days Hours Min.	Sept. 2	1, 1965	New	Jersey
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10	0d. Inside City Limits
	Mary -f she	tor	Virginia Accomac Atlantic				1 ☐ Yes 2 🛛 No
	th the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	What Coun	try?
	ath wi	ral	Atlantic Road - P. O. Box 5 23303		US.		
	after deal or Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - America ck, White, e	
\ 036	urs af	by	3 Widowed 4 Divorced Year or Dates:		Specify.	_{v:} Blac	ale.
<i>§ /</i> 5-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or Items 23e or 28e-f show ent, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	kina	16b. Kind of Bu		
7 121	within one. then "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	9	.		
J 421	be filed within 72 hours after death with the Marylan ital Hygiene. ed other then "neturel", or Items 23e or 28e-f show event, the Medical Examinar must be natified at	e Co	12 homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle,	Domes		
2 Ian	should be fand Mental Barked of	o B	Eddie Worthy Ethel (,	
Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)
24	r 23 = 3		Willie Mae Worthy/mother-in-law 303 Buck Road - Elk T				
H. H. altimore,	a 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location -		
, <u></u>			'4 □ Donation 5 □ Other (Specify) Land of Canaan Cem. 02/2. 21. Signature of Funeral Service Licensee) 22. Name and Address of Facility 121		Glassbo	ro, N	lew Jersey
_ 	permit. Departn Importe eny inju		Loutta D. Jolley Memorial Cha	apel		Salisu	21801
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. A CUTE/RENAL HAILURE	E 			I DAY
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	7 #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	1//			
	ecuted and -transit	Examiner	if any, flading to immadiate cause. Enter Underlying Cause, Disease or injury that initiated events countries that the cause (Disease or injury that initiated events countries to consequence of the countries of	1///	MINER		
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687		edlcal	d.				
Вох	eath certific attending p	M/us	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 3 Destroy death 3 Destroy death 3 Destroy		23d. Dat	te of deliver	ry
O. B	Attending Physicien: The law requires that the death certif rofeth. roteath. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown 1 □ Unknown 1 □ Unknown		Mo	nth [Day Year
S, P.	res that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use conti	ribute to the	e cause of death?
b ord	w require been signature		MYOCAR DIAL INFARCTION HIYPERTENSION	1 🗆 Y	′es 2□No	3 Proba	ably 4 🖫 Unknown
カルルイル Division of Vital Records,	The faw cate has to page 2 s	Completed	FIFFERIENSION		med?	prior to com death?	psy findings available apletion of cause of
ia Z	icien: Th	Be Co	25. Was case referred to medical 26. Place of Dea	1 ☐ Yes		1 ☐ Yes 2	2□ No
\$ Z	hysici nis cer I direc	ToE	examiner/ X Yes 252 No			er (Specify))
200	ding Physicien: n. After this certific funeral director,		27. Manner of Death 1 ★ Natural 5 □ Pending 28a. Date of Injury 1111 k		ow injury occurr		unk
isio	for Attend after death Director: ,	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office unk	28f. Location (S	itreet and Numb	er or Rural	Route Number.unk
D.	in the	Certification:	4 Homicide Adetermined 4 Homicide Adetermined 4 See. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)	City or Ton	m, State)		Allip
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the or rred at the time, o	ause(s) and ma date and place, a	nner as sta and due to	ited. the cause(s)
	To the within To the complex c	ž	29b. Signature and title of certifier Yellow, M.D 29c. License number D 4696	2	29d. Date signed	1 (Month, D	18 2005
	18 Da		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHIRAZI, M.D. 31575 WINTER PLACE P				
4.4	Sta		31. Date filed (Month, Day, Year) FEB 2 2 2005 32. Figistrar's Signature FEB 2 2 2005				
	Registr	ar	LED HA LOOS STREET				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Day | **Physician** 11-1 /Medical ame (If not institution 4b. City, Town or Logation of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Dec. 12 5. Social Security Number 7. Age (In y last birthday Birthplace (State or Foreign Country) **Funeral** 10XM 201 73 Director 1931 Maryland 213-28-7053 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after desth with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 exercises any injury or other traumatic evant, the Medical Exercises on 28a-1 exercises. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Nes 2 □ No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6118 Majors Lane 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No 1952 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crew Chief WSSC 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Wittaker Susie Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Wittaker-Wife 6118 Majors Ln Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Crestlawn Cem. 2/19/2005 Marroittsville,MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signature of Funeral Service Licensee N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or P.O. Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions continu eath but not resulting)in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 Yes or Attanding Physician: director, 25. Was case referred ! Be medical 26. Place of Death (Check only one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 TYes 1 Dinpatient 2 ER/Outpatient 3□ DOA 28a. Da e of Injury (Month, Day 28h Time of Manner of Peath 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To tha Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certific 8

Registrar

State

31. Date filed (Month, Day, Year)

18 2005

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n 			State of Mar State Unpend Item 23a,27,28a-1	yland / Depa per me (artment of Health and 1841 3-18-05 tas rtificate of Death						
	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Dorothea B. W	alch		2. Date of Death Month February	Day Year				
	/Medic Examin		ia. Facility Name (If not institution, give street and number)	aisii	4b. City, Town, or Location of Dea		4c. County of Death				
			Potomac River near Chesapeake & Ohi	o Canal (In yrs. last birthday)	Bethesda	s. 8. Date of Birth	Montgomery				
	Funeral Director		5. Social Security Number 6. Sex 1 ← M 2 1 ← F 7. Age 1 → 1 ← M 2 1 ← F 7. Age 1 ← M 2 1 ← F 7. Age 1 ← M 2 1 ← F 7. Age 1 ← M 2 1 ← M 2 1 ← M 2 M F 7. Age 1 ← M 2 M 2 M F 7. Age 1 ← M 2 M 2 M F 7. Age 1 ← M 2 M 2 M F 7. Age 1 ← M 2 M 2 M F 7. Age 1 ← M 2 M 2 M F 7. Age 1 ← M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	61 Yrs.	Months Days Hours Mir	ov. 5, 1	9. Birthplace (State or Foreign Country) 943 Philadelphia,				
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	ith the Ma or 28e-1 e e notified	Director	rginia Fairfax	Falls (10f. Zip Code	10	1 ☐ Yes 2 ☐ No g. Citizen of What Country?				
	23a or	ai Dir	2329 Senseney Lane		22043		U.S.A.				
36	after dea or Items	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Every Armed Forces? 1 Yes 2 No		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
5-00	"neturel",	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of w	orking 1	6b. Kind of Business/Industry				
Maryland 21215-0036		Completed by	Elementary/Secondary (0-12) 1 2 College (1-4or 5+) + 4	/ife.	DO NOT use retired) ancial analyis		FDIC				
nd 2	illa Partition	BeC	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, M	· ·				
ylaı	should ba find Mental his marked of	Lo Lo	Theodore Hilton Bud		DOTOT		uerite Meell				
	2 60 60		19a. Informant's Name/Relationship (Type, Print) Nicholas R. Walsh – hu								
ore,	es 1 and 2 of Health fitem 27 I		20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3 ☐ Removal from State _	20b. Place of Dispo	osition (Name of matory or other place)	Date 2	Oc. Location - City or Town, State				
Baltimore,	permit. Pages 1 Department of F Importent: If ite any injury or ot		`4 □Donation 5 □Other (Specify) C	· poi	Cremation Feb.	25, 200	5 Hampstead, MD				
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licensee	M01191 N	2. Name and Address of Facility Myers-Durboraw						
		1	23a. Party Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line Immediate Cause (Final				Onset and Death				
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60,	be executad sician and burial-transit		that initiated events	consequence of):							
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P.O. Box 6	To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year				
Records, P.	uires that the signed by do be detact	by	Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?				
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20	ding Phys n. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury	28b. Time o	nt 3 DOA 4 Nursing	Home 5 Resider	nce 6 XIOther (Specify) Scene winjury occurred				
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Division	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc. Scene	y - At home, farm, st (Specify)	reet, factory, office	28f. Location (Str City or Town Great Fa.	eet and Number or Rural Boute Number. State) Great Falls Park, lls, Va				
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of 2 ☑ Medical Examinar: On the basis of and manner state	examination and/or in							
	To the within To th compl	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, Day, Year)				
	MZ		* Kynth Southall, MD		OCME	F	ebruary 24, 2005				
	0		30. Name and address of person who completed cause of de	ath (Item 23a) (Type,	, Print) 111 Penn St	reet Balt	imore, Maryland 21201				
		ate	31. Date filed (Month, Day, Year) 32. Registration								
	Regist	rar .	1 20 20 2000	en to	Bules						

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Registrar

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			Please 1 - State Registrar	State of Mar	yland / Dep		Health and M	lental Hyg	_	5 07575
· ·	Physici /Medic		Decedent's Name (First, Middle, L Bruce M. William					2. Date of Dea Month Feb.	Day Yea 20 2005	
	Examir Funeral Director		4a. Facility Name (If not institution, g 8895 Frederick 5. Social Security Number 494–14–8121	Road	'In yrs. last birthday Yrs.	Elli	cott City If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(, Year)	
poland	how		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or L	ocation		101 11 102		10d. Inside City Limits
ith the Ma	or 28a-f s	Director	MD Howard 10e. Street and Number		Ellicot	10f. Zip Code			10g. Citizen of What	1 ☐ Yes 2 🙀 No Country?
UUSO hours after death with the Maryland	ral', or items 23a or 28a-f show	by Funeral	8895 Frederick	12. Was Decedent Ev Armed Forces?		21043 Was Decedent of If Yes, specify Cul 1 ☐ Yes 2√2 No	Hispanic Origin? (Spotan, Mexican, Puerto	ecify Yes or No-	Inited Sta 14. Race - Ar Black, W Specify: W	merican Indian, hite, etc.
21215-0036	ien "natural", I Mudisal Ext	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Busine	ss/Industry
LZ pue	al Hygi I other	Be	17. Father's Name (First, Middle, La		18. Mother's Name	e (First, Middle,	Nursery Maiden Surname)			
Σç	of Health and Mental. I item 27 Is marked or r other traumatic eve	2	Harvey Monroe W. 19a. Informant's Name/Relationship Greq Williamson	(Type, Print)			Isabel I of and Number or Rura ck Road I	al Route Numbe	r, City or Town, State	
w -	Department of Hea Important: If Itam eny injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Moderns)	cify)	20b. Place of Disp cemetery, cre Crest Lav	osition (Name of ematory or other pla vn Mem. G 22. Name and Addr	ard. 2/23, ess of FacilityHarr	/2-05 M	20c. Location - City Iarriottsv tzke's Fa	or Town, State ille, MD mily F.H.Inc.
be executed	hysician /Medical /xaminer	cal Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CO CO C	death. Do not en	nter the mode of dy	ing, such as cardiac o	or respiratory and	rest,	Approximate Interval Between Onset and Death
.O. BOX 687		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date of o	delivery Day Year
<u> </u>	been signed by	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause g	iven in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
II Kecords,		Completed						24a. Was a autop perfor	sy prior t med? death	aulopsy findings available to completion of cause of ? es 2 \(\sum \) No
Vite	nis certificate director, pag	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	0 C 5 D 10		26. Place of Deatl			
O	h. After this funeral d	n: To	27. Manner of Death	28a. Dale of Injury	2 ER/Outpatie	of 28c. Inju	ary at		ence 6 Other (Si ow injury occurred	pecity)
DIVISION Of Vital		Certification:	1 1 1 1 2 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 39a Blace of Injury	/ - At home, farm, si	M 1	ork? Yes 2 No	28f. Location (S City or Tow		Rural Route Number,
U	within 24 hours after of to the Funaral Director completely filled in by	Medical C	29a. Certifier (Check only one) 29a. Certifying 2 Medical Ex	Physicien: To the best of aminer: On the basis of e	xamination and/or in	th occurred at the to nvestigation, in my	time, date and place, opinion, death occurr	and due to the coed at the time, o	ause(s) and manner date and place, and d	as stated. lue to the cause(s)
3)û	within 2 To the comple	W	29b. Signature and title of certifier		-ms		8 23 6		brvar	
00			30. Name and address of person who	artingM	0700	Gupe	8236 Rl 1	Balti	MD 21.) } f
	Sta Regist	ate	31. Date filed (Month, Day, Year)	2005 32. Régistrar	s Signature	Lock .				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death Reg. No. 2 1 1 5 1	757
Physician /Medical	1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Year February 16 2005 5:	me or beat 30 an
Examiner	4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death	
	Westminster Nursing Home Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (St	
uneral rector	5. Social Security Number 212-12-3667 6. Sex 91 Yrs. 92 Yrs. 92 Yrs. 93 Yrs. 93 Yrs. 95 Yrs. 9	
28a-f ahow notified at rector	10a. Stete 10b. County 10c. City, Town or Location 10d. fnsic	de City Lin
ect ha	Determore	165 2
r items 23e or 28e-fa niver must be notified Funeral Director	10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.	
b y	11. Marital Status 1 Never Married 2 Married 2 No If Yes, 2 No If Yes, or Dates: 12. Was Decedent Ever in U,S. Armed Forces? 1 No Nover Married 2 No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispenic Origin? (Specify Yes or No-ti Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India Black, White, etc.	in,
edical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
, <u>S</u>	switchboard operator phone company	
o Be	17. Fether's Neme (First, Middle, Last) Thomas Grant Woodland 18. Mother's Name (First, Middle, Maiden Surname) Floy Wingate	
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)	
other traumatic event, the M To Be Comp	Gary Newcomb p.r. P. O. Box 135, Church Creek, MD 21622	
ary or of	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Dorchester Memorial Park 2/19/05 Cambridge MD	.ө
any injury or other trat once.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613	
se the bunal-transit and leading to the bunal-transit and leading	Immediate Cause (Final	And Deat
sian/M	d	
2 should be d pleted by	24a. Wes an autopsy performed? 24b. Were autopsy available properties of death?	osy findin
ractor, pega	1 Yes 24 No 1 Yes	2□ No
	25. Was case referred to medical examiner? 1	
funeral di	1 Yes 2 No	
Completely filled in by the funers Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 6 Could not be determined 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Note to building, etc.)	Vumber,
completely fillad in by	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause and manner stated.	se(s)
Ме	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea	ır)
U	> The Ney Do059552 2/16/2005	-
	30. Name and eddress of person who complet I also of death (Item 23e) (Type, Print) COURTS HANKAR C. WAGANNA 700A POOLE RD WESTMINSTER MD 21157	,
State Registrar	31. Date filed (Month, Day, Year) FEB 1 8 2005 32. Resistrer's Signature	

		For State	State of Maryla		artment of H				005	U and has mad on
Physic		1. Decedent's Name (First, Middle, Last) SEANNETTA G	iddings W	Ilkin		Jean	2. Date of Dea	Reg. No. C ath Day	Year	3. Time of Death 8:40 PM
/Med Exami Funeral	ner	4a. Facility Name (If not institution, give s 108 W. ChIZSA 5. Social Security Number 6. Sex	PEAKE AU	E.s. last birthday)	4b. City, Town, or If Under 1 Year Months Days	Location of Death FIEC If Under 24 Hrs. Hours Min.		50	MZYS	
Director		213-69-4964 1 Usual Residence of Decedent 10a. State 10b. County	M 2014 97	Yrs.		Hours Min.	8. Date of Birt (Month, Da 09-13	-07		MCI
the Maryla 28a-f sho	Director	Md Somer		Cris				10g. Citizen o	of What Cou	1 Nes 2 No
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. n marked other then "natural", or Items 23e or 28a-f show umetic event, the Medical Examiner right to included.	by Funeral	108 W. ChE5H 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	DEAKE 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	,	Was Decedent of Hi f Yes, specify Cuba	2 8 7 ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	- 14. R B	ace - Americal lack, White,	can Indian,
d 21215-0 filed within 72 ho Hygiene. ther then "natur int, the Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupi kind of work done of OO NOT use retired LA	during most of work		16b. Kind of	1	
Maryland 212. d 2 should be filed withir th and Mental Hygiene. ?? Is marked other then traumatic event, the M	To Be		iddings			18. Mother's Nam	Ab 12Th	JAN	NES	
Md 2 Ith a 27 ts		19a. Informant's Name/Relationship (Ty) EUGENE WIKE 20a. Method of Disposition	115 - 50n	19b. Mailir		NO AUE	- 11	Davy 20c. Locatio	Md.	21801
altimore, mit. Pages 1 ar partment of Hea portant: If Item y injury or othe		1 A Buriat 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funerat Service License	emoval from State	cometery, crer	natory or other plac	Tory 2-2		Hopeu	1.1 4	rvid.
Depariment of the police of th		23a. Part1. Enter the disease, or compli	Caross,	3	14 Com	E 5%. C	CrisFi	Eldy	wd.	Z 1817 Approximate
Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Due to (or as a conse	AS	CV D	g, such as cardiac	or respiratory ar	rest,		Interval Between Onset and Death
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68760, tificate be ex g physicien as the burial	ledical	•	1							
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			1	Date of defiv Month	ery Day Year
rds, P. quires that n signed b	b	Part II. Dther significant conditions cor	ntributing to death but not re	esulting in the u	nderlying cause give	en in Part I.		obacco use co res 2 12 No		the cause of death?
al Records, The law requires to cate has been signed, page 2 should be cated.	Completed						24a. Was autor perto 1 Yes		o. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
Vita sician certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	□ EB/Outpation	it 3 DOA Oth	er: 4 Nursing He	h (Check only o		ther (Speci	6.1
on of ding Phy After this funeral o		27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28c. Injun Work		28d. Describe			97
Division of Vital to a to Attanding Physician: "after death. Director: After this certification by the funeral director, p	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)			28f. Location (S City or Tox		mber or Rur	al Route Number,
Hospita 4 hours Funaraf ely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or in	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due t	stated. to the cause(s)
To the within 2 To the complete	W	29b. Signature and title of certifier	N to		29c. Licenso	48098		29d. Date sig		
		30. Name and address of person who co	faumbur	adean	Print) 201	Hall	Hizlu	wy,	Crif	seld, MD
S Regis	tate trar	31. Date filed (Month, Day, Year) FEB 2 3	32. Regionar's Sig	, H	double					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician HEZEKIAh orthy homas 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico egional Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) Hours **Funeral** Days Min. 1 XM 2 F Yrs. 210-40-4850 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "naturel", or Items 23a or 28a-f show the Medical Examinational be notified at 1 DNes 2 □ No MD Wicomico Completed by Funeral Director salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 ·VE deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State of Maryland Elementary/Secondary (0-12) Coilege (1-4or 5+) orrectional 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be flie Depertment of Heelith and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, 9DR2: 17. Father's Name (First, Middle, Last) Be Edward Kuth HodgES Archie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) U. Mashington- - Northy- wit 511 Salisbury ANG. IND Shirley 20c. Location - City or Town, State Date 20a. Method of Disposition 1XBurial 2 ☐ Cremation 3 ☐ Removal from State MD Voterans Cemetry 02-25-05 Hurlock * 4 □Donation 5 □ Other (Specify) 2. Name and Address of Facility and Funeral He mo 30439 Hampden Are. Princess Anne 21. Signature of Funeral Service Licensee HID 21853 lune Sne Approximate Interval Between Onset and Dath 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospitel or Attending Physician: The law requires thet the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Onknown 1 Yes 2 No Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1□ Yes 2∃No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of efter death. Director: After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 | Homicide within 24 hours el To the Funerel C completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAN, COUSTANTS 1340 S. Pivision st 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Day 2 **Physician** YOUNG 11:03 AM MONICA MARIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WORLESTER 8342 NEWARK ROAD NEWARK
If Under 1 Year If Under 24 Hrs. Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Birthplace (State or Foreign Country) 1□ M 2XF Months Days Hours Min 123-36-3943 Yrs. 60 Director 3-8-BRONX, NY NY Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. Couлts 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at Director 1 Yes 2 No Mo. WORCESTER NEWARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 8342 NEWARK ROAD death 21841 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hygiene. I Hygiene. I othar than "natural", or iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. þ Specify: 3 ☐ Widowed 4 ■ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 13 3 COOK CHEF RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi and Mental H is markad of Be RAYMOND YOUNG ျှ ROSE HARMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and 2 ment of Health a lant: If itam 27 is 8342 Newark Road, Newark, Maryland Christine Power (daughter) 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) Anatomy Gift Registery February 21, 2005 Hanover, Maryland permit.
Departimporta ature of Funeral Service Licensee Holloway Funeral Home Professional Association Flino CFSP 501 Snow Hill Road, Salisbury, Maryland Josephan 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CZ/C/NDM2 disease or condition resulting in death) 3 years D120 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fusease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 ₽No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital tha Hospital or Attanding Physician: 25. Was case referred to predical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funaral (1 * Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (It im 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2005 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month HELEN A. YUTZY FEBRUARY 20 2005 11:15AM 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) LA PLATA CHARLES COUNTY NURSING & REHAB. CENTER CHARLES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) Days Hours Months 1 ☐ M 2 ☑ F 216-10-0507 21, 1918 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1- Yes 2□No CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 10200 LA PLATA ROAD 20646 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 25TNo Specify Specify: 3√Widowed 4 Divorced WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER AT HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) WILLIAM ALLEN ESTER PEARL HILD 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17418 TEAGUES POINT RD. HUGHESVILLE, MD 20637 ALICE M. YUTZY / DAUGHTER 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEB. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BRINSFIELD-ECHOLS CREMTRY 21,2005 CHARLOTTE HALL, MD 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL.HME., P.A 21. Signature of Funeral Service License MO0641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) one week Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death?

Physician /Medical Examiner

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attending physicien for use es the bune

signed by the at Id be detached fo

director,

this funeral

within 24 hours efter death. To the Funersi Director: A completely filled in by the fo

To the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examine

Be

2

Certification:

edicai

permit. Peges 1 end 2 st Department of Health end Important: If Item 27 is n any injury or other traun

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

ģ

Completed

Funeral

Director

should be filed within 72 hours after death with the Maryland and Mentel Hygiene.

I marked other than "natural", or items 23s or 28s-f show

Maryland 21215-0020

3altimore,

Item 27 is marked other than "natural", or Items 23s or 25s-f show other traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

6 Could not be

determined

2 No 1 Tes 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

20.	examiner?	 10 1	nedical	
27.	Manner of		Pondine.	

Hospitel: 1 | Inpatient 28e. Date of Injury (Month, Dey Year) investigation

2 ER/Outpetient 3 DOA 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated.

Other:

29a.	Certifier
	(Check onl

2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

29c. License number 554

29d. Date signed (Month, Day, Yeer) FEBRUARY 21, 2005

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ALLENTOWN ROAD SUITE 101 CAMP SPRINGS, MARYLAND 20748 5625 FATIMA HUSSEIN, M.D.

State Registra

31. Date filed (Month, Day, Year) FEB 2 2 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Benjamin 2005 6:30p. Allen March 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Nursing Home Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) **X** M 2□F Months 53 Director 219-52-5138 08 20 SC Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f shov other traumatic event, the Medical Exercites must be notified at 1 XYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4042 Hilton Road 21215 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No 1 Never Married Married ö Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: ğ Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7/ h and Mental Hygiene." 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Tractor Operator Beth Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Allen Juanita Dunbar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Cheryl Allen-Wife 4042 Hilton Road, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: if iten
any injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Funeral Service Licensee King Memorial Park 3/12/05 Baltimore, Md March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear ailure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final Physician 4 days disease or condition resulting in death) /Medical Due to (on as a gonsequence of); Perferation Examiner week! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Metas NIZ The law requires that the death certificate be executed rena Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à FOULUR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in To the Hospital within 24 hours at To the Funeral D 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Physician, D0057459 Hospile 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEKELMAN MD DAVID

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 8 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#13, per FH C841 3/8/05 CC
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Rolph Facility Name (If no 0224 AM Andino 05 /Medical 2005 4a. (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dhny MD 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign (In yrs. last birthday) **Funeral** /ear 1**№** M 2□ F Days Hours Min. 569.88. 7680 3 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit 28e-f show other traumatic evant, the Medical Examiner nust be notified at 1 Yes 2 No MIDDLESEX Director 31 SHE 10g. Citizen of What Country 10f. Zip Code or tlams 23a or SHEARN 08846 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: PUERTO RICAN Baltimore, Maryland 21215-0036 þ Specify: Hispanic 3 Widowed 4 Divorced "naturat Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than 'any ridury or other traumatic event, the Magnes. College (1-4or 5+) Elementary/Secondary (0-12) VICE DRESIDE OKPORATE 17. Father's Name (First, Middle, Last, Be MNDINO 19b. Mailing Address (Street and Number or Rural Route Number, City or SHEARN DRIVE MIDDLESEX, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Pages 1 1 Burial 2 Tremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Vaule 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) 10 days /Medical Examiner Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): I year Thoulks Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown n signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 2 2 No 1 Yes 2 🗌 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 5 Pending To the Hospitel or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-0000 Merch 5; 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

MAR 0 8 2005 t Johns Hupkins Hospital 600 North Wolfe Street, Baltimore, Mayland 21287 Resident State

Registrar

			1 - For State Registrer	State of Ma	ıryland	-	artmen tificate			d Mer		ene	5	07583
	Physici /Medic		Decedent's Name (First, Middle, Last) James		Lee		Art	is		2.	Date of Death Month 01	Day 2005	Year	3. Time of Death 10:30a M
	Examir		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location of De	eath		4c. County o	Death	
		Щ	1845 Montreal Rd 5. Social Security Number 6. Sex		/In con In	st birthday)	Set If Under	ern	If Under 24 H	Hre la	Date of Righ	Anne		
	Funeral Director			M 2□F	70	Yrs.	Months	Days		lin.	Date of Birth (Month, Day, 5-22-3)	Year) A	e. Birth Cou	place (State or Foreign ntry) Pa.
	p		Usual Residence of Decedent			Town or Lo						-		
	Aaryla f shov	ō	Md. Anne Arur	del	TOG. City,	Sever								10d. Inside City Limits 1X Yes 2 □ No
	r 28a-	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of WI	nat Cou	ntry?
	th with		1845 Montreal Rd				2	21144	4			USA		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Expressions the rolling at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:		ĺ	Was Deced f Yes, spec l ☐ Yes 2		spanic Origin? n, Mexican, Pu Specify:	? (Specify uerto Rica	Yes or No- an, etc.)		, White,	
9	2 hour	ted t	15. Decedent's Educ	ation		16a. Deced	ient's Usua	I Occupa	ition		1	6b. Kind of Bus		
215	thin 7 ie. ien "n	Completed	(Specify only highest grade	College (1-4or 5	+)	(Give life. I	kind of wor DO NOT us	k done d e retired	furing most of)	working				
121	filed withi Hygiene. othar than ant, I'm M		12th grade 6	yrs		U.S	S. Air	for		Name (Fi	imt Adiddlo Ad	Milit aiden Sumame		
Maryland 21215-0036	should be fund Mental Parmarkad of	To Be	James		Artis	s			Mary		M .			nmer
ary	2 shou and M is mar	-	19a. Informant's Name/Relationship (Type	oe, Print)		19b. Mailir	g Address	(Street 2	_		oute Number,	City or Town, S	tate, Zij	Code)
	Health tam 27 tam 27		Ola L. Artis	Wife	OOL DI-				l Rd.,					.144
Baltimore,	Pages 1 nent of H int: If ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cer	netery, cren	natory or of	her place		Date .15 – 0		oc. Location - C Arling		
alti.	1. E E E		4 ☐ Donation 5 ☐ Other (Specify)21. Signature of Funeral Service License	е	ALI	lingto 22			s of Facility	15-0.		more,		21202
m	Depa Impo any ir		& lady	, Wan	حبها	M	larch	F.H.	East	1.	101 E.	North A	Ave.	
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	eations that caused e cause on each lin	Θ.		er the mode				spiratory arres	st,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	conseque	ence of):								FIVE YEAR
	Examiner	_	Sequentially list conditions,	NON IN			DEPE	NO	ENT C	DIAB	ETES	MELLI	25-	THREE YEAR
T	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	RCHOCKSTEROLEMIA									
0,0	sician and burial-transit	і Еха	resulting in death) Last	Due to (or as a										
,0928	physic the bi	dicai	€ d				-						+	
9 xo	death certifica attending ph for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome	of pregnan							23d. Date	of deliv	erv
.O. B	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown]Ectopic pro] Other (sp					Mont		Day Year
ds, P	uires that signed to id be deta	by	Part II. Other significant conditions con	tributing to death bu	it not result	ting in the ur	nderlying ca	ause give	on in Part I.		23e. Did toba	. /		he cause of death?
Record	s been 2 shoult	Completed									24a. Was an	24b. W	ere auto	ppsy findings available
-		Com									autopsy perform 1 Yes 2	ad?/ de	ath?	mpletion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				Othe	26. Place of I		. /			
of	Phys ral dir	To To	1 Yes 2 No	28a. Date of Injur	y 2	R/Outpatien 28b. Time of		A Othe Bc. Injury Work	4 Nursin			ce 6 Other		ý)
ion	Attanding Party death, actor: After by the funer	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	м		? (es 2 □ No					
Division	i Pite	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ry - At hom :. (Specify)	ne, farm, str	eet, factory	, office		28f.	Location (Stre City or Town,		or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai C	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of er: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred a restigation,	at the tim	e, date and pl	ace, and ccurred a	due to the cau It the time, dat	ise(s) and mani e and place, ar	ner as s	tated. o the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifier	1/-1	A 4-	ikn	29c	License	number		29	d. Date signed	(Month,	Day, Year)
			Jeffrey K	. vergl	un	12	1	1 3	(711		3	12/0	5	
	12+1		30. Name and address of person who co	npleted cause of de	eath (Item 2	PALL	Print) 5	R	A 6	-4	MARI	cary	, (21042
	Sta	-	31. Date filed (Month, Day, Year)	R 0 8 200	r's Signat	مسيالا	A.	4			C/1 -	hr , , , , , , , , , , , , , , , , , , ,		
	Registi	ar	MA	1, 4	3									

	1	For State Registrar	State of N	Maryland	-	rtment <i>tificate</i>			and Me		jiene Reg. No.	005	07584
Physicia /Medica	n	I. Decedent's Name (First, Middle, I	ADAM	5						2. Date of Dea Month MARC	Day	Year	3. Time of Death
Examine	r 4	a. Facility Name (If not institution, g						Location o	of Death		4c. C	County of Dea	
		Howard County					umb		0411			Howa	
Funeral Director	1	5. Social Security Number 6 075-18-4022	.Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. la:	_	If Under	Days	Hours	Min.	8. Date of Birt (Month, Day Nov. 12	(Year)	Q	rthplace (State or Foreign ountry) .rginia
		Usual Residence of Decedent								NOV. 12	ر <u>ب</u> و.	YIJ VI	rgilla
how	_	10a. State 10b. County		,	Town or Lo								10d. Inside City Limits
Be-f e	ੁ ⊢	Maryland Howard	<u> </u>	C	olumb	-							1 ☐ Yes 2 No
with the or 2	בַ	10e. Street and Number 7235 Talisman La	ane			10f. Zip	045				10g. Citiz	en of What C USA	ountry?
ns 23	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	. 13. V			spanic Orig	gin? (Spec	cify Yes or No-	. 1		erican Indian,
after of the street		1 ☐ Never Married 2 ☐ Married	Armed Force		1				, Puerto F	Rican, etc.)		Black, Whi	
ours a	ρ	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	s:		1□Yes 2	X NO	Specify:				Specify: W	hite
"netr	lete	15. Decedent's (Specify only highest			16a. Deced	lent's Usual kind of worl DO NOT use	l Occupa k done d	ition Juring most	t of workin	g	16b. Kin	d of Business	s/Industry
withir then the Man	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		omemak		,			Own	Home	
be filed within 72 hours after death with the Marylend tall Hygiene. Id other then "neture!, or Items 23e or 28e-f show event, the Mudical Extrafrer matter promited at	a)	17. Father's Name (First, Middle, La	st)			<u> </u>		18. Mothe	er's Name	(First, Middle,			
uid be Menta rked tic ev	0 0	Irvin Basham						Fan	nie N	M. Swia	ın		
2 sho and h is me		19a. Informant's Name/Relationship	(Type, Print)							Route Number			
C, N		Judy A. Harris,	Daughter	20h Pla	7235 ice of Dispo			Lane		umbia,			
in to of the or of the or of	1	20a. Method of Disposition 1 Durial 2 XCremation 3		te cer	metery, cren	natory or ot	her place		3/3/0			•	r Town, State Maryland
DENILITIOTE, INICITY INITIAL AT LETS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene Inportant: if item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Marical Examinational be natified at once.	-	 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 		Meti	ro Cre								haryrand
Depart and Depart		Thomas Grego	·			Cremat 299 Fr	tion cede	Soci rick	ety (Road	Of Mary Baltin	land	Inc. Maryl	and 21228
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that causely one cause on each	sed the death.								· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	,	_	tra	n les	hn	al	hle	eel			Onset and Death
/Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):								
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betr d	Examine	Cause (Disease or injury		20 2 20.100420		1 < h=	Le_	h- C	0-0.1	n A			Year
exect en and rial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or	as a conseque		, , -							
octificate be executed ding physicien and use as the burial-transit	dicai		d			-							
GOrds, P.O. BOX of wrequires that the death certific been signed by the attending p should be detached for use as the control of the control	Mec	IF FEMALE:	220 If upa outpoo	mo of program									
BOX eath cer attendir for use	cian	23b. Was decedent pregnant in the past 12 months?		n 2 □ Fetal of t at time of dea	death 3[Ectopic pre					2:	3d. Date of de Month	elivery Day Year
The law requires that the death The law requires that the death the has been signed by the atter age 2 should be detached for u	hysician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknow			2 0 0 10 (0)							
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aquire en sig		Severe M	remic	, ch	ر دوی	c fe	70	۲		1 🗆 🗅	′es 2 🗆]No 3□F	Probably 4 Wunknown
VICAL RECORDS, icien: The law requires to certificate has been signeretor, page 2 should be	ompieted	faile	ne							24a. Was		24b. Were a	autopsy findings available completion of cause of
	Cod	,								perfo	rmed? 2 X No	death? 1 □ Ye	
ysicien: ysicien: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o			
ding Physics of funeral directions	2	1 Yes 2 240 27. Manner of Death	Manub		R/Outpatier 28b. Time of		8c. Injury	4 🗀 19 0		ne 5 Residente la			ecify)
nding tth. :: Afte	tio	1 Accident 5 Pending investiga	28a. Date of I (Month,	Day Year)	Injury	М	Work	<br Yes 2□	No				
INISION or Attending after death. Director: Afte	ertification;	3 Suicide 6 Could no determin	ed 280. Place of	Injury - At hon, etc. (Specify)	ne, farm, str	eet, factory	, office		2	8f. Location (S City or Tox		Number or F	Rural Route Number,
Itai or Irs aft rel Di	OI												
UNISION OF VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Check only 2 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examination	rledge, deatl on and/or in	h occurred a vestigation,	at the tim in my or	ne, date an pinion, dea	nd place, a oth occurre	nd due to the ed at the time,	cause(s) a date and	and manner a place, and du	as stated. ue to the cause(s)
To the within To the	Me	29b. Signature and title of certifier				29c	. License	number	~~?				nth, Day, Year)
		P,	- tom	>5		The real particular and the second	0	289	48		3	- 2-01	7
3		30. Name and address of person w	no completed cause	of death (Item :	23а) (Туре,	Print)	RI	TAM	1	A	~1	MD	7- 9
2)		30. Name and address of person w	DOOF 38 Red	istrar's Signal	>U 1	e 2	.) {		AUA	< K-		2	0/00
Sta Registra	e ar	MAR US	2003	ASS A	A. S.								

			1 - For State Registrar	State of Ma		d / Depa	artmer	nt of H			ental Hy		2005	07585
1	Physic	ian	Decedent's Name (First, Middle, Last, Decedent's Name (First, Middle, Middle, Last, Decedent's Name (First, Middle, M		11	A 1 -					2. Date of De Month MARCH	nath Day ∠	, 2 ŏö 5	3. Time of Death
	/Medi Examii	cal	4a. Facility Name (If not institution, give 4116 BEVERLY ROAD		well	Ande	4b. City	, Town, or CKVII	Location of		MARCH	4c.	, 2005 County of Death NTGOMERY	11:07A. M
	Funeral Director		377-30-9090		(In yrs. Ia	a <i>st birthday)</i> Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da larch l	th ay, Year)	9. Birth Cour 923 Wash	place (State or Foreign ntry) ington, D.C.
	ne Maryland 8e-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery		Town or Lo	.e							10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number 4116 Beverly Road				10f. Zi	2085 Code	2			_	zen of What Cour	
36	be filed within 72 hours after death with the Maryland nat Hyglene. Id other than "naturel", or Iteme 23a or 28e-f show event, the Midcel Eximiter mast be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🖔 N If Yes, Give Year or Dates:			Was Dece If Yes, spe 1 ☐ Yes	dent of Hi ecify Cuba		in? (Spec Puerto R	ify Yes or No ican, etc.))- 1	4. Race - Americ Black, White, Specify: W	can Indian,
21215-0036	within 72 hou ene. than "naturel he Wadical E	mpleted t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	+)		kind of wo DO NOT u	al Occupa ork done d ise retired,	ution uring most	of workin	g	Mary	nd of Business/In 7 Land Pu	dustry
Maryland 2	ed also be	To Be Co	17. Father's Name (First, Middle, Last) Clarence Gilbert	Farwell		Tea	cher				(First, Middle			
	nd 2 solith ar 27 le r treu		19a. Informant's Name/Relationship (Ty Thomas D. Anderso						nd Number	r or Rural	Route Numb	er, City or	Town, State, Zip	
Baltimore,	Pages 1 and lent of Heelti nt: If item 2: iry or other i		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		ace of Dispo metery, crer Lawn Me	sition (Na natory or	me of other place) M	arch 2005		20c. Loc	cation - City or To	
Balti	permit. Pages 1 Depertment of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licens	, + N	10130				1		al Home			i 20850–2805
8760,	Physician /Medical Examiner	icai Examiner	23a. Part1. Ehler the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	hyper	conseque	ence of):	1.11		such as c	1 1		lives	disesse alar	Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed ate bas been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	□ Fetal o	death 3 □	Ectopic p					2:	3d. Date of delive	ry Day Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death bu	t not resul	Iting in the u	nderlying o	cause give	n in Part I.			obacco us		e cause of death?
al Records,		Completed											prior to cor death?	osy findings available npletion of cause of
Vital	Physiclen: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Xes 2 No	fospital:	t 2 🗆 E	R/Outpatien	t 3 🗆 D0	Othe			Check only o		XOther (Specify	SCENE
ion of	After une	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	, ;	28b. Time of Injury		28c. Injury Work		28	d. Describe I			OCENE
Division	2 0 1 0	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hon (Specify)	me, farm, str	eet, factor	y, office		28	f. Location (S City or Tov	Street and vn, State)	Number or Rura	l Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exemination	sician: To the best of ner: On the basis of and manner stat	examinatio	viedge, death on and/or inv	occurred estigation	at the time	e, date and inion, death	place, an	d due to the	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
)	To t com	Σ	29b. Signature and title of certifier	mile -	PSQ	lolin	290	o. License	number				signed (Month, L	Day, Year)
1	30		39 Name and address of person who co	mpleted cause of de	ath (Item	23a) (Type,	Print) 11	.1 Per	nn Sti	reet			Marylar	nd 21201
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0.8 20	60.	's Signatu	lre la	de							

		Department of Health and M Certificate of Death		07586
Physician /Medical		Atkins	2. Date of Death Month Day Year March 2 Co	
Examiner Funeral	4a. Facility Name (If not institution, give street and number), The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last by	Months Days Hours Min		ath timore City inthplace (State or Foreign
Director	230-07-2333	Yrs. Sylvania Sylvani	January 19, 1917	Virginia
with the Maryla to 128a-f shor te notified at Director		Ellicott City		10d. Inside City Limits 1 ☐ Yes 2 No
3c or 2	1 10e. Street and Number 3169 Pine Orchard Iane #402	10f. Zip Code 21042	10g. Citizen of What C	Country? J.S.A.
5-UU30 72 hours after death with the Maryland 72 hours after death with the Maryland insturel; or litems 23c or 28c-1 show dissal Examplified at other at the modified at eted by Funeral Director	3 Widowed 4 □ Divorced If Yes, Give / Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Am Black, Wh Specify:	nerican Indian, nite, etc. White
d Z 1Z15-UU3 filed within 72 hours Hygiene. ther than "natural", int, the Midded Exi Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Sales		s/Industry Retail
be fill be fill be fill be dotted by some sevent Be	17. Father's Name (<i>First, Middle, Last</i>)	18. Mother's Nam	e (First, Middle, Maiden Surname) unknown	
2 0 0 0 E		b. Mailing Address (Street and Number or Run		
More, IV Pages 1 and nent of Health int: If item 27 ury or other tr	Mr. Wilbur Atkins, II Son 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ery, crematory or other place)	Date 20c. Location - City of	
Dantimor permit. Pages Department of I Important: If ite any injury or o	21. Signature of Funeral Service Litensee	22. Name and Address of Facility Slack Funeral Home		
oertificate be executed certificate be executed ding physician and lise as the burial-transit VMedical Examiner	d	revision on: hematoma	or respiratory arrest.	Approximate Interval Between On et and Death
the death the death y the atter	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)	23d. Date of d Month	elivery Day Year
S, es the digner be d	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ➡No 3 ☐ F	to the cause of death? Probably 4 □Unknown
The law The law ate has b page 2 sl)	26 Place of Part	24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes	
F A Side F	1 ☐ Yes 2 No Hospital: 1 Nonpatient 2 ☐ ER/C	Other: 4 Nursing Ho	me 5 Residence 6 Other (Sp	ecify):
ing ing	27. Manner of Death 1	Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	·
urs eral eral			28f. Location (Street and Number or F City or Town, State)	
To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifler (Check only one) 2 ☐ Medical Examiner: On the best of my knowledge one) 2 ☐ Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier			
Vily Vily Too	Olint Baind M.O.	RES-00	oo March 6	1 2005
5	30. Name and address of person who completed cause of death (Item 23a	Wolfe Street	Bultimore, MO 2	1287
State Registrar	MAR 0 8 2005	General Commence of the Commen		

		1	For Stata Ragistrar	State of	Marylan		artmen				ental Hyg	iene g. No. 2	005	07587
	Physicia		1. Decedent's Name (First, Middle, I	Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		John William A	nderson							March 1	, 2005		6:00 PM M
	Examin	er	4a. Facility Name (If not institution, g		iber)				Location	of Death		4c. County of Death		
			Gilchrist Hos 5. Social Security Number 6		7. Age (In yrs. I	last hirthday)	Ba If Under	ltin	nore If Under	24 Hrs	8. Date of Birth	Ва	1tim	
H	Funeral Director		214-12-2511	1M 2□F	84	Yrs.	Months	Days	Hours	Min.	June 2,	^{Year)} 1920	Mar	nplace (State or Foreign untry) yland
	and	-	Usual Residence of Decedent 10a. State 10b. County	-	10c. City	, Town or Lo	cation						T	10d. Inside City Limits
	Maryl f sho	ō	MD Balti	more		Timoni	um							1 ☐ Yes 2√∑ No
	r 28a	rec	10e. Street and Number				10f. Zip	Code			16	0g. Cîtizen of	What Cou	untry?
	h with	Funeral Director	641 Straffer Dr	ive #402				210	93			TT	SÅ.	
	ema a	ner	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Deced			igin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra		ncan Indian,
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pu	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M.	BeC	17. Father's Name (First, Middle, La						18. Mothe	er's Name	(First, Middle, A	Aaiden Surna	me)	
<u>yla</u>	should bund Ment and Ment marked umatic	2	Albert J. Ande	rson							ra Moone			
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	1 and Health em 27 ther t	Į.	20a. Method of Disposition			lace of Dispo			g Ct		Lutherv	7ille, 20c. Location		21093
Baltimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 '4 ☒ Donation 5 ☐ Other (Spe			emetery, crei	natory or o	ther plac	e)			EGG. EGGGHOTT	Oity of	,
Balti	purmit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tra		21. Sign via Funeral S. rvice Lickonal d. S	Wade, D	trector		Name an	Anat	omy B	board	655 W.	Baltin	nore	Street
			23a. Part1. Enter the disease, or co	omplications that ca	aused the death	n. Do not ent	altimo	ore, e of dyin	MD g, such as	2120 cardiac o	1—————————————————————————————————————	est,		Approximate Interval Between
	Physician	S. 11	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate the efficient of the complete of the cause of condition.											
	/Medical		resulting in death)							weeks				
	Examiner		Due to (or as a consequence of): Sequentially list conditions, b. Dewewt										years.	
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced events.	Liluia to (i	or as a consequ	iisnna attr								
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a consequ	uence of):							-	
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Вох	eath certifica attending ph for use as the	lan/	23b. Was decedent pregnant in the past 12 months?		rth 2 Fetal	Idéath 3□	Ectopic pr						ate of deli	very Day Year
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4	res that the signed by be detact		Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying c	ause give	en in Part I	i.	23e. Did tob	acco use cor	ntribute to	the cause of death?
ecords,	-= 07 73	ed by									1 □ Ye	s 2 🗆 No	3 Pro	obably 4 Unknown
900	aw is but 2 st	Completed									24a. Was a		. Were aut	topsy findings available
α	Th ate pag	Com									perform		death?	2 □ No
/ita	ysician: This contificate director, pag	Be (25. Was case referred to medical examiner?	11				24			(Check only on			
of	S S S	2	1 ☐ Yes 2 No 27, Manner of Death			ER/Outpatier 28b. Time o		A Cith	er: 4 □ Nu		me 5 Reside		her (Spec	in Waspec
on	Jing After fune	tion	Natural 5 Pending		of Injury h, Day Year)	Injury	M	8c. Injun Worl	γαι k? Yes 2□		28d. Describe ho	w injury occu	IIIea	
Division of Vital	Attending r death. sctor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place	of Injury - At ho	ome, farm, sti	eet, factory				28f. Location (St.	reet and Nun	ber or Ru	ral Route Number,
ā	s afte	Certification:	4 Homicide determin	buildir	ng, etc." (Specify	Y)					City or Towr	i, State)		
	To the Hospitel or Attend within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	29a. Certifier Check only one 2 Medical Ex	Physician: To the kaminer: On the ba and mann	asis of examina	wledge, deat tion and/or in	h occurred vestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ca ed at the time, da	ause(s) and nate and place	nanner as , and due	stated. to the cause(s)
	To th To th comp	M	29b. Signature and title of certifier	1					number	2		9d. Date sign		
			Whee		(4)		I) S.	330	5	n	norch	2	2007
_			30. Name and address of person w						8 11	r B	alters	e and	212	roy
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 8	2005	gistrar's Signa	lture	house	,						

march 1,2005

Anderson, John

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 25, 2005 **Physician** 1:10 am Hunter F. Blackburn, Jr. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carrol1 4321 Beckleysville Road Hampstead If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. July 15, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Mary Land 1 Q M 2 □ F 218-28-9196 71 Director Usual Residence of Decedent Pages 1 and 2 should be lifled within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene. The marked other than "natural", or items 23e or 28e-f ehow ant: If item 27 is marked other than "natural", or items 23e or 28e-f ehow ury or other traumatic event, The Medical Event in at must be notified at ury or other traumatic event, The Medical Event in at must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Hampstead Md. Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 U.S.A. 4321 Beckleysville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years construction operating engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hunter F. Blackburn, Sr. Regina P. Meushaw 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4321 Beckleysville Road, Hampstead, Md. 21074 Dorothy Blackburn/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once: 4 □ Donation 5 □ Other (Specify) 2/28/2005 Glen Burnie, Md. Glen Haven Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cardiomyopathy /Medical Due to (or as a consequence of) Examiner CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed ASCVD burial-tran Due to (or as a consequence of) attending physicien Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, page 2 should be COPD 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an NIDDM autopsy performed? certificate 1 Tes 2 1 No 1 Yes 2 🗌 No or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 \overline{\o Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours To the Funeral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. fo the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D17150 tamelo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1447 York Road, Lutherville, Md. 21093 Rolando Vieta, M.D., 31. Date filed (Month, Day, Year)
MAR 0 8 2005 32. Registrar's Signature State Registrar

				For State Registrer	State o	f Maryland /	Depar	rtment	of H		and M	ental Hy			075	589
		Dhysisi	20	1. Decedent's Name (First, Middle, I								2. Date of De Month		ay Year	3. Time o	of Death
	1	Physici /Medic		Clyde Calvin Be	nnett							March	4,	2005	7:50	РМ
E C		Examin	er	4a. Facility Name (If not institution, g				-		Location o	of Death		4	c. County of Death		
pa				Gilchrist Center 5. Social Security Number 6	r For Ho	SP1CE 7. Age (In yrs. last bi	intholous)	If Under	Tows		24 Hre	O Date of Di	45	Baltimo		
+		Funeral Director		244 03 8440	1 <mark>⊠</mark> M 2□F	93	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nov. 15	in iy, Yea 1 O		place (State untry)	
				Usual Residence of Decedent								NOV. 13	19	II Nort	h Caro	Mina
4		inylan ihow	_	10a. State 10b. County		10c. City, Tov									10d. Inside C	
Tool		Sa-f	cto	Maryland Baltim	ore	E	Essex									s 21 No
سل		with the nor 2 be no	吉	10e. Street and Number 803 S. Marlyn 2	Atzonijo			10f. Zip	Code 212	21			10g. C	itizen of What Co	untry?	
		eath ns 23	Funeral Director	11. Marital Status		edent Ever in U.S.	13 W	as Deced			gin? (Spe	oify Ves or No		USA 14. Race - Ame	ican Indian	
5	(0	ifter d	표	1 ☐ Never Married 2 ☑ Married	Armed Fo	rces? 2. □ No	1					ecify Yes or No Rican, etc.)		Black, White	, etc.	
March	5-0036	ral', o	by	3 Widowed 4 Divorced	If Yes, Gir Year or D	Ve	1[Yes 2	No No	Specify:				Specify: Wh	ite	
_	5-0	72 h	Completed	15. Decedent's (Specify only highest of	Education grade completed)	168	a. Decede (Give ki	nt's Usua ind of wor	l Occupa	ation during most	t of worki	ng	16b.	Kind of Business/l	ndustry	
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de	d 2	filed Hygid Sthar		17. Father's Name (First, Middle, La	st)	1				18. Mothe	r's Name	(First, Middle	, Maide			
Clyde	an	ild be lental ked c	To Be	Arthur Bennett								oneycu		,		
0	Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar than "natural", or Hems 23a or 28a-f show aumatic event, It a Modical Exertifier must be notified at		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing	Address	(Street a	and Numbe	or or Rura	I Route Numb	er, City	or Town, State, Z	ip Code)	
+	2	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, Ite Mydical Examinar Institute thaillied at		Doris L. Bennet	t (Wife)								e, N	Md. 21221		
Sewneth,	Baltimore,	iges 1 if iter or oth		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3	☐Removal from	20b. Place cemete						ate		Location - City or		
EN	ţ	mit. Pa partmen cortant: injury	١.,	'4 □Donation 5 □Other (Spe	2	Holly						/2005	Ba.	ltimore,	Maryla	ınd
a	Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		21. Signature of Funeral Service Lice	Kausko		Br	uzdz:	insk	ss of Facilit i Fun	eral	Home 1	P.A.	k. Md. 21	221	
				23a. Part1. Enter the disease, or co	mplications that of	aused the death. Do								Sp 1910 2	Approxima Interval Be	ite
	M	Physician		Immediate Cause (Final disease or condition			ente	-							Onset and Years	Death
		/Medical Examiner		resulting in death)	Due to	(or as a consequence									7803	
		Cxammer	J.	Sequentially list conditions,	b. — Due to	(or as a consequence	a =0:									
		ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence	e or):									
\$	\	ate be executed hysician and the burial-transit	Exar	that initiated events resulting in death) Last	c. Due to	(or as a consequence	e of):									
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	68	rtifical ng ph		IS SEMAN S.	-											
	Вох 68	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregnancy pirth 2 Petal deat	th 3 □E	Ectopic pre	egnancy					23d. Date of deli		W
	O. E	ie dez the at hed fo	sici	1 Yes 2 No	4∐Pregr 9∐Unkn	nant at time of death own	5 🗆 (Other (spe	ecify)	· · · ·				Month	Day	Year
	P.O.	that the de ned by the a detached f		Part II. Other significant conditions	s contributing to d	eath but not resulting	in the unc	derlying ca	ause alv	en in Part I.		23e. Did	obacco	use contribute to	the cause of	death?
	of Vital Records,	o De	d by			g	,	sorrying oc	auso givi	OIT III T WIT 7.	,				bably 4	
	Ö	s been si should	Completed									24a. Was	an	24b. Were au	opsy findings	available
	Re	The law te has l	omp									auto perfo	ormed?	prior to death?	ompletion of	cause of
	ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical						26. Place	of Death	Check onl		10 10 165	20110	
		ding Physician: The In. After this certificate ha funeral director, page	To	examiner? 1 ☐ Yes 2 ♠No	Hospital: 1 🗆	Inpatient 2 ER/C	Outpatient	3 🗆 DO.	A Oth	өг. 4 □ Nu	rsing Hor	πe 5 ☐ Resi	dence	6 Other (Spec	ity) HOSE	ICE
	n c	ding P	on:	27. Manner of Death 1 Natural 5 Pending		of Injury 28b. th, Day Year)	. Time of Injury		Bc. Injury Work	at k?	2	28d. Describe				
	isio		icat	2 Accident investigat 3 Suicide 6 Could no	be One Diese	of laine. At home		М		Yes 2□!		39f Location /	Ctront	and Number or Ru	1	
	Division	after Direction by	Certification:	4 Homicide determine	build	of Injury - At home, I ing, etc. (Specify)	iaim, stree	et, ractory,	, опісе		-	City or To	wn, Sta	te)	rai Houte Nun	nder,
		To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	dical C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the	best of my knowledgesis of examination a	ge, death	occurred a	at the tim	ne, date an	d place, a	and due to the	cause(s) and manner as	stated.	· · · · · · · · · · · · · · · · · · ·
		the F the F riplete	Medi	une)	and man	ner stated.		-			Journal of the second of t	2 21 110 11110,				21
		To To		29b. Signature and title of certifier	1 Atic	rder Phys	1Cion			5 number	456	7	290. D	ate signed (Month	, Day, Year)	
		0-		30. Name and address of person wh	no completed servi	#18501CQ) /Tuna n	rint)			-	1		12/02		
	_	.7		DAVID BEKELM	AN MD	660	/ N	C	44R	LES	ST.	BA	147	0. md-	7122)4
	6	Sta Registi		31. Date filed (Month, Day, Year)	72. F	Registrar's Signature	Goard	W								
	15.0			MAR 0 8 20	UJ ASS	MAN I										

State of Maryland / Department of Health and Mental Hygien 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Wilbur James Barger 2005 March 4, 7:00a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1714 Cape May Road Essex Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 21, 1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral Ж**М 2□ F **Director** 193-14-6420 80 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Medical Exer-described by notified at Maryland Baltimore 1 Yes 20 No Essex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 1714 Cape May Road 21221 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No 194 If Yes, Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1943 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: 1946 3€XWidowed 4 □ Divorced White natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Westinghouse other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Mental itsm 27 Is marked o Wesley George Barger Zura Ella Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 Cape May Road, Baltimore, Maryland 21221 Wesley Barger (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition jo <u>=</u> ō 1 ☑ Rurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Dulaney Valley Mem. Gar. 03/08/05 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 40 Ca Physician /Medical Due to (or as a consequence of): Examiner ONU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit 97 Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: use If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No funeral director, page 2 1 Yes 2 ₽No To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Certification: To 1 🔲 Yes 252 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C completely filled 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00028949 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panayiotis A. Baltatzis, M.D. 1232 Race Rd. Suite 102 Balto., Md. 21237 37 Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 8 2005 Registrar

			1 - For State Registrar	State of N				nt of H	lealth	and N			0 ()5	07591
	Dhyoisi		1. Decedent's Name (First, Middle, La	st)							2. Date of D		ay	Yeer	3. Time of Death
	Physici /Medic		John Thomas Buc				,				MARCH			2005	2:50 P M
	Examin	er	4a. Facility Name (If not institution, give		r)				Location	of Death		4	c. Count	y of Death	
			St. Agnes Hosp		han //m vern	In at hirthday		Balti r 1 Year		r 24 Hrs.	O Date of P	inth		O Birth	Jana (Canana Esperimental
	Funeral Director			Sex 7.7 1 123 M 2 □ F	79	last birthday) Yrs.	Months		Hours	Min.	8. Date of B (Month, L Nov . 14	ay, Year	25	Mary	lace (State or Foreign try) 1 and
			Usual Residence of Decedent		13					1.	INOV.14	r o L	725	mary.	Land
	how how		10a. State 10b. County		10c. Ci	ty, Town or Le	ocation							1	0d. Inside City Limits
	e Ma	cto	Maryland Baltimo	re	Cat	onsvil	le								1 ☐ Yes 2 ☐ No
	다 50 년 10 20 년 11 년	Funeral Director	10e. Street and Number					p Code				10g. C	itizen of	What Cour	ntry?
	ath w	ral	309 Osborne Avenu					228						ISA	
	er de Items	une	11. Marital Status	12. Was Deceder	s?	J.S. 13.	Was Dece If Yes, spe	edent of Hearing Cuba	ispanic Oi in, Mexica	rigin? (Sp in, Puerto	pecify Yes or No Rican, etc.)	10-		ce - Americ ick, White,	
36	irs aft	by F	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates			1 🗆 Yes	2 No	Specify	<i>'</i> :			Speci	_{fy:} Wh	ite
9	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itema 23a or 28a-f ahow The Medical Exacilizat must be notified at		15. Decedent's E			16a. Dece	dent's Usu	al Occup	ation		, .	16b.	Kind of E	Business/In	dustry
215	within 7 ene. than "n	ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	kind of wo	use retired	auring mo d)	st of won	king				
21	filed wit Hygien ther the	Completed		1		Audi	tor			., .				ervic	2
pu	d la b	Be (17. Father's Name (First, Middle, Las)							ne (First, Middi		n Sumai	me)	
yla	should by	2	Hugh B. Buckholz								Carmack				
Maryland 21215-0036	s 1 and 2 should if Health and Men Item 27 is marks other traumatic		19a. Informant's Name/Relationship	Type, Print)							ral Route Num	_			
	s 1 and f Healt ltem 2 other t		Phyllis Buckholz 20a, Method of Disposition		wife 20b.	Diana of Dian	anisiam (Ala		-		Data	00-1	Ma location	aryla: - City or To	nd 21228
و	Pages nent of h unt: If Ite		1 ⊠Burial 2 ☐ Cremation 3 [te La	cemetery cre ike Vie	matory or W Mer	other place	rk	3/11		Syke		-	Maryland
Baltimore,			' 4 □ Donation 5 □ Other (Special Service Lice												
Ba	permit. Departr Importa any inju				0129	20	Ster	ling	Asht	on S	Schwab	Fune	ral	Home,	Inc.
Gg	4411		23a. Part1. Enter the disease, or con shock, or beart failure. List only	plications that caus	ed the dea	th. Do not en	ter the mo	de of dyin	g, such a	s cardiac	or respiratory	arrest,	SVII	ie, v	D 21228 Approximate Interval Between
	Physician		Immediate Cause (Final	A A	10 X I	ic 6	BRA	11	IN	70	RY				Onset and Death
	/Medical		disease or condition resulting in death)	DUA to (or a	as a consec	TURNCR Off:							17		DAG
- 12	Examiner		Comment the line and distance	, AC	UTE	- RE	ENA	4	FA1	LUI	RE				2 DAYS
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	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				4 /	NE	ASCC	170.					4 DAYS
760,	ate be executed hysicien and he burial-transit	cal E)	Tosaking in south, cast	Due to (or a	as a consec	quence or):									
687	× × =			≧ d											
×	leath certificate attending phy I for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcon	ne of pregn	ancy							23d D:	ate of delive	arv.
Вох	atter 1 for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			□Ectopic p □ Other (s		·					onth	Day Year
P.O.	that the de ted by the a detached	hysl	9 Unknown	9□ Unknown											
	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	by PI	Part II. Dther significant conditions	contributing to death	but not res	sulting in the u	Inderlying	cause giv	en in Part	1.	23e. Did	tobacco	use cor	ntribute to t	ne cause of death?
Vital Records,	w require been sig should b										1 🗆	Yes :	2 No	3 Prob	ably 4 Unknown
000	aw re	Completed									24a. Ws	s an	24b.	Were auto	psy findings available mpletion of cause of
Ä	The late happened	E O									per 1 □ Yes	formed?	lo	death?	2 No
ita	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?						26. Plac	e of Dea	th (Check only	one)			
of V	Physic this ce al dire	10	1 ☐ Yes 2 No	Hospital: 1 Npa	itient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4 🗆 N	lursing H	ome 5 Re	sidence	6	her (Specif	y)
n o	ding Ph h. After th funeral	:uo	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time o		28c. Injun Wor			28d. Describe	how inj	ury occu	rred	
sio	tendi leath. for: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not l	00			М		Yes 2]No	201	(011			
Division	of attending Physician: after death. I Director: After this certific d in by the funeral director,	Certification:	4 Homicide determined	200. Place of	Injury - At h etc. (Speci	iome, farm, st ify)	reet, factor	ry, office			City or T			ber or Hura	l Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying P	hysicien: To the be	st of my kn	owledne des	th occurred	d at the tim	na date s	nd place	and due to th	e Cause/	s) and m	anner as c	tated
	24 hi 24 hi 3 Fun etely	edical	(Check only 2 Medical Exa	miner: On the basis and manner	of examina	ation and/or in	ivestigation	n, in my o	pinion, de	ath occu	rred at the time	o, date a	nd place	, and due to	the cause(s)
	ompl	Me	29b. Signature and title of certifier			4 6 4	29	c. Licens						ed (Month,	
)	- A		> Teodora 1	Warles	du	MD		PI	760	5		M	MRC	H, a	6,2005
0	119					m 23a) (Type	, Print)		,		- 4:	4	n.a	A	
6	1.		30. Name and address of person who TEODORA NICULE SCI	IMD, STAC	WES A	1058ITHZ	, 900	CATOI	v .40	ENUE	- 131	L-1119	URE	170	21229
	Sta Registi		31. Date filed (Month, Day, Year)	-	strar's Sign	ature	and !								

ORIGINAL

BUCKHOLZ, JOHNT

	1	For State Registrar		Department of Health and I Certificate of Death	Reg	2. No. 0 0 5	07592
ysiciar Iedica amine	1	1. Decedent's Name (First, Middle, L HENRYD, BUNG I.a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of Death	2. Date of Death Month 03	Day Year O 05 4c. County of Death	3. Time of Death 240 P
eral ctor		214-18-9814	Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1)	(ear) 9. Birth	nplace (State or Fore untry) MD
THE COL				own or Location			10d. Inside City Lin
at be notified		10e. Street and Number 833 Stamford		10f. Zip Code 21229	100	g. Citizen of What Cou	untry?
Injury or other traumatic event, the medical examiner must be notified at 8. To Be Completed by Europe Director		11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? **Types 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White	ican Indian,
Medical	Completed by	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king	6b. Kind of Business/l	ndustry
B C C	u u	4th grade 17. Father's Name (First, Middle, Las		Construction Worke	er C ne (First, Middle, Ma	onstruct niden Sumame)	ion Co.
T C		Edward Bundy 19a. Informant's Name/Relationship		9b. Mailing Address (Street and Number or Ru	ral Route Number, (
	_	Brenda Queen-Do 20a. Method of Disposition XIXBurial 2 Cremation 3	□ Removal from State	33 Stamford Road, of Disposition (Name of Itery, crematory or other place)	Date 20	c. Location - City or T	own, State
any Injury once.		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice	Gall	ison Forest Vet. 3 22. Name and Address of Facility March F/H West		1,50	
ian ical		23a. Part1. Ent r nor disease, or conshock, or hear failure. List only immediate Cause (Final disease or condition resulting in death)	mplications that Aused the death. Do yone cause on each line. a	4300 Wabash Ave pool on the other the mode of dying, such as cardiac body.			21215 Approximate Interval Between Onset and Deatl
er	Valillie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)				
6	2		d				
hy Physician/Madic	1 yalcıdırımı	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1			23d. Date of deliv Month	rery Day Year
to by De	בי ב	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.		cco use contribute to	the cause of death
Completed	- January				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause
	ָ ב	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1-1 Inpatient 2 ER/	Othor	th (Check only one)	ce 6 □Other (Speci	(fy)
direct		27. Manner of Death 15 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	o. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how		
cation. To B	Cation	2 () 100100111		farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
Certification To B	Celtification	3 Suicide 6 Could not 4 Homicide determine	building, etc. (Specify)				
polical Certification: To B	Celtification	3 Suicide 4 Homicide 6 Could not determine	building, etc. (Specify) hysicien: To the best of my knowled	lge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the caus	se(s) and manner as s a and place, and due t	stated. to the cause(s)
ig L	Medical Columbano	3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specify) hysicien: To the best of my knowled miner: On the basis of examination.	and/or investigation, in my opinion, death occur 29c. License number P17668	red at the time, date	se(s) and manner as se and place, and due to Date signed (Month,	Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

05-1623 ZACHERY BLACK Amend Item#6, per For State of Maryland / Department of Health and Mental Hygiene 1 5 Certificate of Death Reg. No. 1. Decedent's Name (First_Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ACHER MARCH 2005 10:13 A /Medical 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day April 2 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
 Country) 219.78.5025 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Era pher must be notified at 10c. City, Town or Location 10d. Inside City Limits MD ALTIMORE Director 1 FYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 1 If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) TELEMARKETER IELE COMMUNICATIONS marked other 17. Father's Name (First, Middle, Last) t and 2 should be fill Health and Mental H 19a. Informant's Name/Relationship (Type, permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other p thod of Disposition Burial 2 Cremation 3 DRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral in ice Licensee 23a. Part1. Enter the disease, or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PHEUMONIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cluce (Disease of lighty that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 → es 2 □ No autopsy 2 No 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 X Yes 2 No 2 X ER/Outpatien1 3 DOA this After this funeral of 27. Manny of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation neral Director: , filled in by the f 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 5, 2005 Myrie w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREL 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed Month

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07594 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 8:32 pM 03 CELESTA BROWN MARIE 4 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death GENESIS ELDER HEALTH CARE PARKVILLE BALTO. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗓 F 89 04-27-1915 NC <u>246-16-2472</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD BALTIMORE DUNDALK 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 CENTER PLACE 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced lf Yes, Give Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NURSE HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELVIN BROWN CARRIE B. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 TAYLOR AVENUE, BALTO., MD 21236 POLLIE DEL PINO/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removal from State **METRO** 3/8/05 BALTO., MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H., INC 22. Name and Address of Facility 1701 LAURENS STREET, BALTO., MD 21217 23a. Part. Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ement Due to (or as a consequence of) rial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cerebry van Due to (or as a consequence of): 23d. Date of delivery egnancy Month Day Year ecity) ause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

Director: After

within 24 hours a

Division of Vital Records, P.O. Box 68760.

permit. Pages
Department of H
Importent: If ite
any injury or of

Physician

/Medical

Examiner

Director

Funerai

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Completed

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Director

r then "netural", or items 23s or 28e-f show

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ent 1 is marked other then "netural", or Ite

Baltimore, Maryland 21215-0036

death with the Maryland

Examiner attending physician a for use as the burial-Physician/Medical s been signed by the 2 Completed Be Certification: To filled in by the

		d	Hyphys	daen
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	atcome of pregnancy birth 2 Fetal death nant at time of death nown	3 ⊟Ectopic pro
	Part II. Other significant condition	~ De	elme	the underlying ca
	Degens	altre	Jonet	DIFE
)	25. Was case referred to medical			

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Comple	Degenso	the Jonet Du	flar	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical		26. Place of Death	(Check only one)
To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hom	e 5 Residence 6 Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at 28 Work?	3d. Describe how injury occurred
Certific	3 Suicide 6 Could not b 4 Homicide determined		actory, office 28	8f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical (29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investiging and manner stated.	urred at the time, date and place, ar ation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
ž	29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

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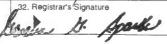
State Registrar

MAR 0 8 2005

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31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

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		1	For State Registrar	State of	of Marylan		artment of H		nd Mental Hy	giene,	005	07595
	a.		1. Decedent's Name (First, Mic	idie, Last)					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medic		Joyce C. Bagw	ell _					March	•	2005	9:15 AM M
	Examin		4a. Facility Name (If not institut	ion, give street and nu	imber)		4b. City, Town, or	Location of	f Death	4c. C	County of Death	
			Gilchrist Cen	ter for Ho	spice Ca	are		Towson		Ва	ltimore	!
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 20X F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	8. Date of B (Month, D	irth a <i>y, Year)</i>	9. Birth	place (State or Foreign intry)
	Director		410-26-2801 Usual Residence of Decedent	12 11 29	82	Yrs.			08/29	/1922	TN	
	and and		10a, State 10b. Cour	nty	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	f sho	5	MD Bali			. 1						1 ☐ Yes 2 No
	288 288	Director	10e. Street and Number	imore	Coc	ckeysv.	10f. Zip Code			10g. Citiz	en of What Cou	intry?
	3a or		14205B Greenc	moft Tono			21030				ed Stat	•
	ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U		Was Decedent of H	ispanic Orig	in? (Specify Yes or N		4. Race - Amer	ican Indian,
9	after or Ite		1 Never Married 2 M	Armed F	orces? 2 No ive		1.7		Puerto Rican, etc.)		Black, White	, etc.
9	ral', c	by	3 Widowed 4 □ Divorce	ed Year or [Dates:		1□ Yes 2 No	Specify:			Specify: Whi	te
21215-0036	i within 72 hours after death with the Maryland jiene. rithen "natural", or Items 23e or 28e-f show the Medical Evaninar must be notified at	Completed		ent's Education hest grade completed)		dent's Usual Occup		of working	16b. Kin	d of Business/li	ndustry
21	C * 60	npi	Elementary/Secondary (0-12		1-4or 5+)	life.	DO NOT use retired	1)		Own	Home	
	filed within Hygiene. other than rent, the M		12	4- (4)		Homer	naker	40 14-4	d No (5° A6' A	14.11.		
and	o d ta	Be	17. Father's Name (First, Midd						's Name (First, Middl		sumame)	
Maryland	d 2 should be the and Menta the marked? I is marked traumatic events.	2	Frederick Cl			10h Maili	Add (Chant		aret Rose J	_	Town Chain 7	in Code)
Mai	12 sh ar		19a. Informant's Name/Relation Jacquelyn A. H		ahtor		,					_ ′
	1 an Heal em 2 ther	1 1	20a. Method of Disposition	nandiey/ Dat	20b. F	Place of Dispo	sition (Name of	I	Lane Cocke	_	Le, MD	
ية	o to		1 □ Burial 2 ☑ Crematio	n 3 Removal from	State	emetery, cre	matory or other plac	1	Mar 7			
Baltimore,			'4 □Donation '5 □ Other 21. Signature of Funeral Servi			21	ke Cremat Name and Addre	-	2005	Belt	sville,	Maryland
Ва	permit. Departr Importa any inju		21. Signature of a different service	60.11	MOO	984 6	Cremation	and Fu	neral Alte			
			23a. Part1. Enter the disease,	or complications that	caused the deat				res Drive		more, Ma	Approximate
Н			shock, or heart failure. L Immediate Cause (Final	ist only one cause on	each line.		•					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Lems 1.	177C	ponore	anc	Carica			acontur
	Examiner			Due to	(or as a conseq	uence or):	•				4	
1		P.	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):						-
1/	be executed sician and burial-transit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events	1								
v í	exec in an		resulting in death) Last	Due to	(or as a conseq	uence of):			,			
8760,	cate be ohysicia the bur	dicai		d								
9	The law requires that the death certificate be executed ate has been signed by the attending physician and bagee 2 should be detached for use as the burial-transit	a a										
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna birth 2 ☐ Feta		DEctopic pregnancy	,		23	3d. Date of deliv	•
	deat	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No		nant at time of d		Other (specify)				Month	Day Year
P.0	at the de by the stached	hy	9 ☐ Unknown									
	res tha igned I be det	by	Part II. Other significant cond	litions contributing to	death but not res	ulting in the u	inderlying cause giv	en în Part I.		L	1	the cause of death?
ord	w require been si should I		-						1	Yes 2	No 3∏Pro	bably 4 Unknown
Records,	e law r has be je 2 sh	Completed							24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
ď	The I	Om							per 1 ☐ Yes	formed?	death? 1 ☐ Yes	
Vital	sician: Th certificate rector, pag	Be (25. Was case referred to med examiner?	ical					of Death (Check only			
of V	5 in	2	1 ☐ Yes 2 No			ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nur	rsing Home 5 Re			drospice
п	ding Ph h. After th funeral	ü	27. Manner of Death 1 → Matural 5 □ Per	28a. Date	of Injury oth, Day Year)	28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe	how injury	cocurred	
Sio	tendi eath. tor: A	cati	2 Accident inve	estigation				Yes 2□N				
Division	or At fter d Sirect n by	Certification:		arminad 286. FldC	e of Injury - At h ding, etc. <i>(Specil</i>	ome, farm, st 'y)	reet, factory, office		28f. Location City or T	(Street and own, State)	Number or Rui	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		no casilla Se casi	hilas Dhanislas Tast			4		d ataon, and due to the	/ - >		
	Hos 24 ho Fun Fun	Medical	29a. Certifier 1 Certification (Check only 2 Medic	lying Physician: To the last Examiner: On the	basis of examination basis of examination of examination of examination of examination of the examination of	tion and/or in	n occurred at the tir evestigation, in my o	ne, date and pinion, deat	h occurred at the time	e cause(s) a e, date and l	and manner as place, and due	stated. to the cause(s)
	o the ithin o the	Med	29b. Signature and Title of cert		mior statou.		29c. Licens	e number		29d. Date	signed (Month	, Day, Year)
	⊬ ≯ ⊬ 8		k 1 km	oun N			D	58	503			
			30. Name and address of pers	on who completed cou	ise of death (Ito-	n 23a) /Tun~	Print)	- U	1		``	
	1()		AA)CIN O HA	LUES WO	6001	N - (larles	JT 1	503 BOLTINO	up in	0 21	204
	Sta	ate	31. Date filed (Month, Day, Ye	32	Regular's Signa		1. 4.			-		
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	1	For State Registrar	State of Mar	-	rtment of H	lealth and Me Death		iene	5 07596
Physicia	ın	Decedent's Name (First, Middle, Las Harry Brown	t)			2	Date of Dear Month F > b V u	Day	Year / 8 / 25 M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County o	
		824C Wynstream Wa	У			Edgewood		Harfor	rd .
Funeral		5. Social Security Number 6. Se	MA OFF	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
Director	-	217-64-5338 Usual Residence of Decedent	2NM 2LIF	48 Yrs.			08/22		ID
and **	-	10a. State 10b. County		IOc. City, Town or Los	cation				10d. Inside City Limits
Mary -f sho	ত্	MD Harford		Edgewood					1 ☐ Yes 2 No
r 286	<u>s</u>	10e. Street and Number		Lugewood	10f. Zip Code		1	l0g. Citizen of Wi	hat Country?
h witi	<u>a</u>	824C Wynstream Wa	v		21040			United :	States
deat	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S. 13. V	Vas Decedent of H	ispanic Origin? (Specin, Mexican, Puerto Ri	ify Yes or No-	14. Race Black	- American Indian,
36 safte		1 Never Married 2 Married	1 ☐ Yes 2 No	1	☐Yes 2000	Specify:	•	Specify:	
OO;	pd by	3 Widowed 4 Divorced	Year or Dates:		lant's Llaus Casus	ation		16b. Kind of Bus	Black
15-	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of working	7	Hospita.	· ·
within than	dwo	Elementary/Secondary (0-12) Unk	College (1-4or 5+)	Waite		,		nospica	LICY
yland 21215-0036 Juld be tiled within 72 hours after death with the Maryland Mantal Hygiene. Anked other than "natural; or iteme 23e or 28e-f show atic event, If a Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)		1		18. Mother's Name (First, Middle,	Maiden Surname	1)
lan lid be fental rked ric ev	To B	Unknown Unknown				Unknown	Unknown		
S PEE		19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street	and Number or Rural	Route Number	r, City or Town, S	State, Zip Code)
and 2 and 2 ealth a n 27 is		Charlene Brown/Wi	fe	824C	Wynstrea	m Way Edge	ewood,	MD 2104	0
Baltimore, Dermit. Pages 1 at Department of Hea mportent: If Item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place	Da M	te ar 8	20c. Location - 0	City or Town, State
imor Pages nent of I	- 01	'4 □Donation 5 □ Other (Specify		Chesapeal	ke Cremat	ory Inc. 2		Beltsvil	le, Maryland
Balt permit. Depart import any inj		21. Signature of Funeral Service Licen	soon Mod	3 4 0 1 1	. Name and Addre	ss of Facility and Funeral	Altern	atives	
death certificate be executed Wedical Washington Wa	Ilcal Examiner	23a. Part1. Enter the disease, or compostock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Figure 1) that initiated events resulting in death) Last	a Due to (or as a b Due to (or as a c.	consequence of): consequence of): consequence of):	er the mode of dyin	ig, such as cardiac or	respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetel death 3	Ectopic pregnancy Other (specify)	1		23d. Date Mon	e of delivery ith Day Year
ecords, P.O law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	_	bute to the cause of death? 3 Probably 4 Unknown
The The ate h	Completed						24a. Was a autop: perfor 1 Yes	sy pi med2 de	Vere autopsy findings available rior to completion of cause of eath?
of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		O#	26. Place of Death			
<u>— ≥ isi</u> D	J.	1 Yes 2 No	1 ☐ Inpatien 28a. Date of Injury			er: 4 Nursing Hom		lence 6 Othe	
ding I	tion	1 XNatural 5 ☐ Pending	(Month, Day		Wor	k? Yes 2□No		or injury occurre	
Division I or Attending after death. Director: After din by the fune	flca	3 ☐ Suicide 6 ☐ Could not b		y - At home, farm, str					or or Rural Route Number,
Div A affer affer Dire	Certification:	4 Homicide	building, etc.	(Specify)	,		City or Tow	n, State)	
Division or To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		ysician: To the best of niner: On the basis of and manner state	examination and/or in					
o the	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed	(Month, Day, Year)
->=0		> 11 Forker,	777		215	314	/	March	7,2005
1		30. Name and address of person who	completed cause of de	ath (Itemy 23a) (Type,	Print)	/	/ /		1.
		HEarkas, MI	1 gra 50 m	s/Novi	Lern C	he sup can	le Hus	pice, E	7,2005 Ikton, Mp
Sta		31. Date filed (Month, Day, Year) MAR 0 8 2005	32. Registra	's Signature	20	,	., .,	,	
Regist	ar	CUUS O D AAM	partie .	la l					

			For State Registrar	State of I	Marylan	-	rtment tificate					gieņe Reg. No.	005	07597
	Dhysisi		1. Decedent's Name (First, Middle, Last)								2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Le	on W.	Brown						March	4,	2005	10:20 P M
	Examin		4a. Facility Name (If not institution, give s		er)				Location of	of Death			County of Dea	
			Manor Care-Betheso 5. Social Security Number 6. Sex		Ann days 1	and hinth days	Bet.	hesd	a If Under	24 Hrs	O Data of Biot		ontgome	
	Funeral Director			M 2□F	Age (In yrs. I	Yrs.	Months	Days	Hours	Min	8. Date of Birt (Month, Da February	15, 1	.918 Mi	rthplace (State or Foreign Country) SSOUTÍ
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Many a-f sh	ţo	Maryland Montgome:	rv	Bet	thesda								1 ☐ Yes 2 🎇 No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of What C	Country?
	23a	aic	5109 Wickett Ter	race			20	814				Unit	ed Sta	ites
	r dea	Funerai		 Was Decede Armed Force 	157		Vas Deced f Yes, spec	ent of Hi	ispanic Ori	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)		 Race - Am Black, Wh 	
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	IT Yes, GIVE	□No Wor		I □ Yes 2	2[X No	Specify:				Specify:	***
9	72 hours after death with the Maryland natural', or Hems 23s or 28s-f show Jissi Exertinative molffic dist	edt	15. Decedent's Edu	Year or Date	s: War		lent's Usua	I Occupa	ation			16b Kir	nd of Busines	hite s/industry
21215-0036	J within 72 hours after death with the Marylan jene. r than "natural", or Items 23a or 28a-1 show the Medical Example at mark to notified at	Completed	(Specify only highest grade	completed)	0.5.\	(Give	kind of wor OO NOT us	k done d	durina mos	t of worki	ng		f Equi	•
212	d within giene. rr than "	Eo	Elementary/Secondary (0-12)	College (1-4	or 5+)	Vice I	resi	dent	/Gener	al M	lanager		tribut	•
힏	be filed ital Hygid of other event, the	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
<u>Va</u>	should be I ind Mental I s marked o	ပို	Oscar Loren Brown						Elsi	e Ma	e Downs	5		
Maryland	2 8 8 8		19a. Informant's Name/Relationship (Type				-				al Route Numbe			
	of Health Item 27 other tr		Betty L. Brown/W: 20a. Method of Disposition	lfe	20h P	5109 lace of Dispo					Betheso		larylar cation - City o	
و	ages if Ite		1 N Burial 2 ☐ Cremation 3 ☐ R	emoval from Sta	rte Par	emetery, crer cklawn	natory or o	herplac rial		larch	18,			
Baltimore,	it. Partiment intent		'4 □Donation 5 □ Other (Specify) 21. Signal □ □ Ineral Service Ligense	20		Par	ck		2	2005	ort A	Rock	ville,	Maryland Tuneral Home/
Ba	permit. Pages. Department of the Important: If Ite any injury or ot once.		1.32:01 1	μυ	. MOO8	303 R	ockvi ockvi	He;	Inc. Mary	300 land	West 1	10nt 8	comery 5	Avenue
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cau	sed the death h line.	n. Do not ent	er the mode	e of dyin	g, such as	cardiac o	or respiratory as	rest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	Cer	ebrova	ascula	Acc:	iden	t					1 Month
	/Medical Examiner		resulting in death)		as a consequ									
		-	Sequentially list conditions, if any, leading to immediate cause. Enter unuarying).	nerosc] as a consequ		3							Years
	nsit	i i	Cause (Disease or injury											1
<u>,</u>	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last		as a consequ	uence of):								
8760,	ate hy:	cai		l										
9	eath certifica attending ph for use as tl	Physician/Med	IF FEMALE:	3c. If yes, outcome	mo of progna	nov								
Вох	attend for us	ian	in the past 12 months?	1 Live birth	n 2 ∏ Fetal tat time of de	Ideath 3□	Ectopic pro					1	3d. Date of d Month	elivery Day Year
o.	at the de by the a tached i	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		saut 3L	Journal (sp	ecily)						
a	that ned by deta	by Ph	Part II. Other significant conditions cor	tributing to deat	h but not resu	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco u	se contribute	to the cause of death?
rds	quires n sign uld be		Parkinsons Disc	ease							1 🗆 `	Yes 2[□No 3□F	Probabiy XXUnknown
Records,	The law requires that the ste has been signed by the bage 2 should be detache	Completed	Old Cerebrovas	cular Ac	cident	-					24a. Was		24b. Were	autopsy findings available
Ä	The l	Eo										rmed? 2 XNo	death?	completion of cause of
Vital		Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 🛣 No		atient 2		198.74	on the same	44 <u>1</u> NU	rsing Ho	me 5 🗆 Resid	dence (5 □Other (Sp	ecify)
n c		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of I (Month,	Injury Day Year)	28b. Time of Injury	1	8c. Injury World			28d. Describe I	now injur	y occurred	
Sic	eat or:	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	Inium. At he	ma farm ot-	M (astan		Yes 2 🗆	-	29f Location (Stroot an	d Number or I	Rural Route Number.
Division	after d Direct in by i	Certification:	4 Homicide determined	building	, etc. (Specif)	y)	eet, ractory	, onice			City or Tox			nurai Acute Nurriber,
	Hospital 24 hours 6 Funeral 1 nely filled		29a. Certifier 1 Certifying Phys	sician: To the be	est of my kno	wiedge, deati	occurred	at the tin	ne, date an	d place,	and due to the	cause(s)	and manner	as stated.
	To the Hospital of within 24 hours af To the Funeral Completely filled in	Medical	(Check only one) 2 Medical Examin	ner: On the basi and manner		tion and/or in				ith occurr				1
	To You		29b. Signature and title of certifier	. 0	108				e number					nth, Day, Year)
,	1/		A Clibe	07	VV)	0001 7		D313	19			Marc	ch 7, 2	2005
	201		30. Name and address of person who co				,	Aven	11e #	305	Bethes	sda.	Marv1s	and 20814
	Sta	ate	31. Date filed (Month, Day, Year)		istrar's Sîgna				11	505,	Decires	, uu ș	y 10	20017
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygjene 🛭 🖔 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Warren Garfield Bareis 2005 /Medical March 7 1:30A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Augsburg Lutheran Village Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F 104-14-6061 83 Vrs Director New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23e or 28a-f show 1 ☐ Yes 2 No Completed by Funeral Director Marvland Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6811 Campfield Road 21207 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Items 23e eny Injury or other traumatic event, the Wedforl Examinat must appear. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant State of New York 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Bareis Lillian Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas W Bareis Son 2207 Green Haven Way Hampstead Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cedar Grove Cemetery □Donation 5 □Other (Specify) 3/10/05 Queens, New York 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 40CARDIA **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Certification; To Be Completed by Physician/Medical the. as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death the i 9 Unknown 9 Unknown Part II. Pther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, EZLITUS 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 2D No 1 ☐ Yes o the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 18 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sucee 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) 7220 31. Date filed (Month, Day, Year) MAR 0 8 Registrar's Signature State Registrar

			1 - For Stata Registrar	State of N	Maryland / Dep Ce	partment of I			gierie	05	07599)
	9		1. Decedent's Name (First, Middle,	Last)				2. Date of De.	ath Day	Vand	3. Time of Death	
	Physici /Medi		Mollie Ma	ryann	Bauer			02	25	Year 2005	4:30 P	М
	Examir		4a. Facility Name (If not institution,	give street and numbe	r)	4b. City, Town,	or Location of Dea	ath	4c. Coun	ty of Death		
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	Funeral		,	1. Sex 7. / 1 □ M 2 XX F	Age (In yrs. last birthda	Months Days		n. (Month, Da	h y, Ye <i>ar)</i>	9. Birthp	ace (State or Forei	ign
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	and w		10a. State 10b. County		10c. City, Town or	Location				1:	0d. Inside City Limi	its
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Sio	Attending r death." ector: Attending	catl	2 Accident investiga 3 Suicide 6 Could no	nt he			Yes 2 No	-				
Division	or At after of Direction by	Certification;	4 Homicide determin	288. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		City or Tox	Street and Nur vn, State)	nber or Rura	l Route Number,	
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	24 h	edical	(Check only 2 Medical E	xaminer: On the basis	of examination and/or	investigation, in my	opinion, death oc	curred at the time,	date and place	e, and due to	the cause(s)	
	To the Hospital or Attending I within 24 hours after death. * To the Funeral Director: Atter completely filled in by the funer	₩	29b. Signature and title of cortifier	100	• ^ -		se number		29d. Date sign			
				1 O V V J	ON DO	143	4400	\ (MARC	H3,	2002	
	\cap		30. Name and address of person w	ho completed cause of	f death (Item 23a) (Typ	a Print)				/		
	1,7			IN MAL	KICL .	NONTH A	NUMF-	THONIN	AC			
	Sta Regist	ate rar	31. Date filed (Month, Day Year) MAR 0 8 200	5 32. Regi	strar's Signature							

	1	For Stata Registrar	State o	of Maryla		artmen <i>rtificat</i>			nd Me	ental Hygio	ene ()5	07600
Physician /Medical	ı	. Decedent's Name (First, Middle		Davis B	ailey, J	lr.				2. Date of Death Month	Day ch 3, 200	Year 05	3. Time of Death 9:55 a.
Examiner	4	A. Facility Name (If not institution Social Security Number	3005 Gree	nway Dr.	. last birthday)	4b. City,		Location of	Ellico	ott City	4c. County	of Death	oward
Funeral Director		215-30-8577 Jsual Residence of Decedent	11 2 M 2□F	go (myro	70 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 1 November (place (State or Fore ntry) Pennsylvania
ne Maryland 8a-f show pilified at		0a. State 10b. County Maryland	Howard	10c. C	ity, Town or L	ocation	E	llicott Ci	ty				10d. Inside City Lim 1 ☐ Yes 2
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State Registrar		31. Date filed (Month, Day, Year)	W.	Registrar's Sign	lature Sono	W	}						

	Physic	ian	1- Stata Registra AMEND ITEM# 23e PER PHY G84 1. Decedent's Name (First, Middle, Last)		LI/ V / UII		2. Date of D Month March	eath Day	JAN-	3. Time of Death
	/Medi Exami	cal	Patrick Joseph Barrett, 4a. Facility Name (If not institution, give street and number)	III	4b. City, Town, o	r Location of Death	1		2005	6:35 Рм
	LAdiiii	liei	Greater Baltimore Medical Cente		Towson			Balt	imore	
	Funeral Director		5. Social Security Number $085-42-7683$ 6. Sex $1 \boxtimes M$ 2 \square 7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth Pay, Yea <i>r)</i> 28, 195	9. Birthp Count 1 New	lace (State or Foreign htry) YOCK
	land w		Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	own or Lo	cation				1	0d. Inside City Limits
	Mary B-f sho	tor	Maryland Harford Bel	Air						1 ☐ Yes 2 ☐ No
	ath with the Marylar 23s or 28s-f show	Dire	10e. Street and Number	-	10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	death v	erai	501 Mayfield Lane 11. Marital Status 12. Was Decedent Ever in U.S.	13. \	21014 Vas Decedent of H	lispanic Origin? (Si	pecify Yes or N	USA 0- 14. R	ace - Americ	an Indian.
98	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itams 23a or 28a-f show event. The Mudical Examinat must be notified at	by Funeral Director	Armed Forces? 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 🌠 No	dispanic Origin? (S) an, Mexican, Puert Specity:	o Rican, etc.)	Spec	lack, White,	etc.
tからた S 21215-0036	72 hours "natural",	ted b	15. Decedent's Education	6a. Deced	lent's Usual Occup	pation	trim -	16b. Kind of	Whi Business/Inc	
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	o the Pithin 24 o the Formplete	Medi	one) and manner stated. 29b. Signature and title of certifier		29c. Licens		1	29d. Date sign		
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V	- 1		30. Name and address of person who completed cause of death (Item 23	a) (Type,	Print)	- : (_	Δ	
	(Manglall A. Levila 10569 1	ophla	Chambes	Suite	205 T	OWISA.	nilla	WILLIC proporty
•	St	ate	Manstull A, Leville 6569 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Charles	Suite 2	205 1	00050	n) Ma	nyland 21264
	Regist	rar	Mansfull A. Levine 6569 N		Charles	Suite 2	205 1	01150	n) Ma	nyland 21214
DI		rar	Mansfull A. Leville 6569 N 31. Date filed (Month, Day, Year) MAR 0 8 2005			Suite 2	205 T	01150	n) Ma	nyland 21214

State of Maryland / Department of Health and Mental Hygiene [] [5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 9:45 P M BAILEY 03 01 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛣 F 269-10-1398 Yrs. Director 88 Ohio Usual Residence of Decedent with the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Exposurar traval to notified #1 1 ∏Yes 2 TVNo Director Florida Duval Jacksonville Beach 10e. Street and Number 10g. Citizen of What Country? 1701 The Greens Way Unit 1631 32250 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Callege (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Julyy or other traumatic svent 2008. Be William A. Nell (uk) Ziegler Disney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 The Greens Way, Scott D. Bailey / Son Jacksonville Beach, FL 32250 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊞ Burial 2 □ Cremation 3 □ Removal from State '4 □Donation 500ther (Specify) EntombmentBel Air Memorial Grdns. 3-5-05 Bel Air, Maryland 21. Signature of Funeral Service Licenaee 22 McCondagrefuferal Home, P.A. Murles U. Cyca 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only section on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ande resulting in death) /Medical Due to (or as a consequence of): Examiner el Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner to (or as a consequence of) The law requires that the death certificate be executed burial-transil the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Whiknown has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dias 5032255 Mazer 2. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MD 31. Date filed (MM/A Pay, 0.08 2005 Registrar's Signature Registrar

				For State Registrar	State of	of Maryla		artment of F		Mental Hy	ygieże() ()	5	07603
				1. Decedent's Name (First, Middl	e, Last)					2. Date of D	eath		3. Time of Death
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		Examin		4a. Facility Name (If not institution	n, give street and nu	ımbər)		4b. Cily, Town, o	r Location of De	ath	4c. County	of Death	
				Upper Chesape	ake Medica	al Cent	ter	Bel A	ir		Harf	ord	
1		Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 H		irth	9. Birthp	lace (State or Foreign
7		Director		201-01-8283	1□M X 1F	8	35 Yrs.	Montals Days	Tiodia W	Mar.	18,1919		nsylvania
7		pu »		Usual Residence of Decedent 10a. State 10b. County		100 (City, Town or Lo	anti-					
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		with th	i i	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
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0		ours after death with the Mar rei", or items 23a or 28a-f sh Examiner must be notified	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Man	Armed Fe		U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	Io- 14. Haci	e - Ameno k, White,	an Indian, etc.
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ho	5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturei", or ttems 23a or 28a-f show int. It a Medical Examinat must be redified at			t's Education		16a, Dece	dent's Usual Occup	ation		16b. Kind of Bu	Whj	
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	land	of the page	10 B	Wilbert	(nmn)	Harfo	ord		Laura	Chri	stina	Tre	acher
	ary	€ 5 E E	_	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Num	ber, City or Town,		
	2	1 and 2 Health a lem 27 Is		Franklin C. B	itt, Jr.	-Son	840	3 Philad	elphia 1	Road, Ba	ltimore,	Mary	land 21237
9	ē	5 - = 0		20a. Method of Disposition		20b	Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location -	City or To	wn, State
0	E	Page nent c		1 ∑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5		i State		Cemetery		-7- 05	Baltimo	re. M	arul and
3	aĦ	permit. Page Department of Importent: If any injury or once.		21. Signature of Frineral Service	Licensee		22	. Name and Addre	ss of Facility	V			at y taria
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\leq		. 10.44		23a. Part1. Enter the disease, or shock, or heart failure. List	the cause on	caused the de	ath. Do not ent	er the mode of dyir	ng, such as card	liac or respiratory	arrest,	111111111111111111111111111111111111111	Approximate Interval Between
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		/Medical		resulting in death)	a. Due to	(or as a cons	equence of):	> 1-	heri			-	
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7	39	death certificate e attending phys id for use as the	Med	IF FEMALE:	1								
2	ô	ath ce	an/	23b. Was decedent pregnant in the past 12 months?		utcome of preg birth 2 Fe		Ectopic pregnancy	y		23d. Dat	e of delive	*
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7	ň		on:	27. Manner of Death Natural 5 ☐ Pendir		of Injury oth, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occurr	ed	
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		urs a urs a srel (00-0-0-									
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		To the Hospitel or Atwithin 24 hours after d To the Funerel Direct	Med	29b. Signature and title of certifie		nner stated.		29c. Licens	se number		29d. Date signed	d (Month	Day, Year)
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	7	Κi		30. Name and address of person	سام مصمامین	ion of docute the	om 22a\ /T =		3227)	W. B.	en 2	15002
		Υ\		30. Name and address of person	wito completed cat			Print)	/ R.	elmir	22.0		
		Sta	ate.	31. Date filed (Month, Day, Year,	32.	Registrar's Sig		e har	/	- 1974	(1)		
		Regist		MAR 0 8		D. C	K L	and p					

			4 101	artment of Health and Mental I rtificate of Death	Hygiene 005 07604
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Norton Barmack	2. Date of Month	Death Day Year 4:50 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Levivolate	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 or 2 or 3	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. MAR .	Birth (State or Foreign Country) 9. Birthplace (State or Foreign Country) MD
	Maryland Iled at	tor	10a. State 10b. County 10c. City, Town or L	ocation BALTIMORE	10d. Inside City Limits 1
	with the 3a or 28s	I Direc	10e. Street and Number 7121 PARK HEIGHTS AVENUE #209	10f. Zip Code 21215	10g. Citizen of What Country?
36	be filed within 72 hours after death with the Maryland and Hygiene. An Hygiene death with then "natural; or Itams 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Married 2 Married 1 Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Married Forces?	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 🕅 No Specify:	
21215-0036	filed within 72 hou Hygiene. Ither than "nature int, the Medical E	Completed	(Specify only highest grade completed) (Given life. Elementary/Secondary (0·12) College (1·4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) LESALER	16b. Kind of Business/Industry
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Maryland	and Mental and Mental is marked o aumatic eve	2		MACK FREDA ing Address (Street and Number or Rural Route Nu	GERSUK Imber, City or Town, State, Zip Code)
	1 and 1 Health em 27 ther tr		SHALE STILLER / ATTORNEY 622 20a. Method of Disposition 20b. Place of Disp	5 SMITH AVENUE - BALTIM	ORE, MD 21209 20c. Location - City or Town, State
Baltimore,	0 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	UNO ARLINGTON 3/6/2005	BALTIMORE, MD
Balt	permit. Pag Department Imp. rtant: any njury o		21. Signature of Funeral Service Licensee		INSON & BROS., INC.
	nysician		Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	nter the mode of dying, such as cardiac or respirato	ry arrest, Approximate Interval Between Onset and Death
Tare 1	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):		months
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on of	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28d. Descr Work? M 1 ☐ Yes 2 ☐ No	ibe how injury occurred
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Location	on (Street and Number or Rural Route Number, Town, State)
	o the Hospital	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the best of my k	ath occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
	withi Tot com	¥	29b. Signature and Title of certifier W	29c. License number D 00 6 2 4 0 4	29d. Date signed (Month, Day, Year) 3/2/2005
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Jenn Her Lamberg M). Print) Levindale). 2434 W. Beived	lere Baltimore MD
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 8 2005	W	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 2, ື2005 **Physician** Year **BLOOM** MINNIE 12:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth MAY 14, 1916 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🙀 F 88 Yrs. Director 212-03-8204 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner a ust be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 Items 23e USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 Never Married 2 Married 5 altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: 3 X Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mentai YOSPA MORRIS KATIE SPIVAKOV 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth Item 27 MORRIS BLOOM / SON 2322 CAVESDALE ROAD - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 \$\infty\$ Burial 2 □ Cremation 3 □ Removal from State

`4 □ Donation 5 □ Other (Specify) SWINICHER WOLINER CEM 03/06/2005 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medlcal attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Year 5 Other (specify) 9 Unknown 9 Unknown s been signed by should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 25. Was case referred/to medical 26. Place of De examiner?

Division of Vital Records, certificate has birector, page 2 s Hospitel or Attending Physician: this funeral After within 24 hours efter deat Fo the Funeral Director: filled in by

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ath (Cl	heck only one)	
Home	5 Residence	6 ☐Other (Specify

Other: 4 Jursing I 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

30. Name and address of person who completed cause of death (Item 23a) (Type.

State Registrar

0

DHMH 17 Rev 1/2001

Certification; To

Medical

1 🗌 Yes

27. Man r of Death

2 Accident

4 Homicide

3 Suicide

29a, Certifier

1 Natural

2 ☑ No

5 Pending

investigation

6 Could not be determined

31. Date filed (Month, Day, Year) 32. Registrar's Signatu

	1	For 1 - State Registrar	State of Ma	aryland / Depa	artment of Hea	Ith and Men	tal Hygie	-	07606
Physicia /Medic			DELIA	BASSINGER			Date of Death Month	Day Year 01 2005	3. Time of Death 11:00 A M
Examine Funeral Director	Completed by Funeral Director	MARINER HEALTH (5. Social Security Number 195–16–9582	OF FOREST H	ILL e (In yrs. last birthday) 79 Yrs.		ILL Jnder 24 Hrs. 8, [Date of Birth Month, Day, Y	HARFORD (ear) 9. Birt Co 1925 Pe	
		Usual Residence of Decedent 10a. State 10b. County Maryland Harfo	ord	10c. City, Town or Lo		np.	L. • / / J	1929 16	10d. Inside City Limits 1 ☐ Yes 2 🕱 No
th with th		10e. Street and Number 2205 Roth Road			10f. Zip Code 21040		100	g. Citizen of What Co USA	untry?
21215-0036 I within 72 hours after death w iene. rthen "natural", or Itams 23e		11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 No Sp	nic Origin? (Specify exican, Puerto Rica pecify:	Yes or No- n, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland ith and Mental Hygiene. Zt is marked other than "natural", or Itams 23s or 28s-f show traumatic event, the Medical Exameter interior indiffed at		15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or 5	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) naker	g most of working	16	6b. Kind of Business/ Own Hame	
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		19a. Informant's Name/Relationshi Barbara Stone 20a. Method of Disposition			ng Address (Street and P 5 Roth Road,		d, Mary	yland 2104	.0
Page Page ment ent: fi		1 □ Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spe	ecify)	Holly Hi	matory or other place) Ll Mem. Parl	3-8-0	5 Ba	altimore,	Maryland
Balt permit. Departi		21. Signature of Funeral Service Licensee Mocona's Funeral Home, P.A.							
Physician are be executed by sician and prival transit the burial transit		shock, or heart failure. List of timmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.		with Liv				Interval Between Onset and Death
O. Box 68' It the death certificate by the attending phy lached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
rds, P.	by	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	inderlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records, siclen: The law requires to certificate has been signe rector, page 2 should be or	Completed	25. Was case referred to medical						prior to d	topsy findings available completion of cause of
Sion of tending Phys leath. tor: After this the funeral di	ledical Certification: To Be	examiner? 1 Yes 2 Yo 27. Manner of Death 1t Autural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	t be	y Year) 28b. Time o Injury	ont 3 DOA Other: f 28c. Injury at Work? M 1 Yes	28d. 2 🗆 No	5 Residence Describe how	ce 6 Other (Spec	
Divi: To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by 1		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						etated	
To the Hospitel within 24 hours a To the Funeral I completely filled	Medi	29b. Signature and title of certifier	and manner sta	ated.	29c. License nur			d. Date signed (Month	
Ŋ		30. Name and address of person w DR. MANUEL LAZA			*	21001		witch of	
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 2		ar's Signature	W.				

		•	For State Registrar	State of Maryland / D	epartment of Hea		ygiene	5 07607
	g		Decedent's Name (First, Middle, Last)			2. Date of D	eath	3. Time of Death
	Physici		Edislood	BLACK WE	//	MARCH	Day	Year 8:49 A. N
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Lo	7.77	4c. Count	by of Death
	CXallill	ei	GILCHRIST /	HOSPICE.				LTIMORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtl	nday) If Under 1 Year If	Under 24 Hrs. 8. Date of B	irth	
	Director		212-48-9285	M 20F 57 Y	rs. Months Days	Hours Min. (Month, L	Day, Year)	9. Birthplace (State or Foreig Country)
		9	Usual Residence of Decedent			Niel !	1777	1-1MX /ZANG
	ylan		10a. State 10b. County	10c. City, Town	or Location		_	10d. Inside City Limits
	Mar	Director	Md N	A BALTI	MORE			1, Yes 2 □ No
	r 28c	irec	10e. Street and Number	1 10//0/5	10f. Zip Code		10g. Citizen of	What Country?
	3a o		816 n Page	STREET	21-	205	11	S. A.
	72 hours after death with the Maryland natural', or itams 23a or 28e-1 show lites Evantins must be rodified at	Funerai	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispa	anic Origin? (Specify Yes or N	lo- 14. Ra	ice - American Indian,
G	r ita	Ē	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No		Mexican, Puerto Rican, etc.)		ack, White, etc.
5-0036	al', o	by	3 ☐ Widowed 4 ☑ Divorced	ITYes, Give Year or Dates: 1968 - 72	1 ☐ Yes 2 No S	Specify:	Speci	ity: BLACK
9	72 hours natural', lical Ex	Completed	15. Decedent's Educ	ation 16a.	Decedent's Usual Occupatio	on ,	16b. Kind of B	Business/Industry
218	within 72 ho ene. than "natur he Medicel	pie	(Specify only highest grade	College (1-4or 5+)	(Give kind of work done duri life. DO NOT use retired)	ing most of working	CHARLE	es Hickey
2	d wit	ПО	1273	NIA G	OUN SOLER		SHOOL	FOR BOYS
g	be filed stal Hygi od othar evant, I	Bec	17. Father's Name (First, Middle, Last)		18	B. Mother's Name (First, Middle		
ā		To E	UNKNOWN	/		HANEY	Black	tule 11
Maryland	2 shou and N is mai		19a. Informant's Name/Relationship (Type		Mailing Address (Street and	Number or Rural Route Num	ber, City or Town	n, State, Zip Code)
ž	s 1 and 2 should f Health and Mer itam 27 is marks other traumetic		SHAYONNE BLACE	Enter Churche &	6 7. FORT	ST BOUTO	. m	. 21205
<u>o</u>	s 1 a f Hea itam othe	-3	20a. Method of Disposition	20b. Place of	Disposition (Name of crematory or other place)	Date	_	- City or Town, State
9	Pages nent of int: if it		1X Burial 2 ☐ Cremation 3 ☐ Ri '4 ☐ Donation 5 ☐ Other (Specify)		ON FOREST UE TEL	3/10/05	Melteric	Mus md.
Baltimore	E 65 ⊃		21. Signature of Funeral Service Lipense	e/	22. Name and Address of	of Facility BEVERLY	D Co.	HILLS MIC.
ä	permit. Departr Importa any inji		Acuell 1	rounité	21121 5	DITUED ST	Kaita	MKL. 21213
4	100		23a. Part. Enter the disc se, or compli	cations that caused the death. Do n				Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				Interval Between Onset and Death
偃	Physician /Medical		disease or condition resulting in death)		NECK CA	meer		year
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.89	ificate g physias the	a)						
Вох	eath certifii attending p	N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. D	ate of delivery
m	death atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			fonth Day Year
0	The law requires that the death certifi tte has been signed by the attending I page 2 should be detached for use as	Physician/M	9 Unknown	9□ Unknown				
σ,	that ned b	by P	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given i	in Part I. 23e. Did	tobacco use cor	ntribute to the cause of death?
g	quires n sign ald be	d be				215	Yes 2□No	3 Probably 4 Unknown
00	w requ	lete				24a. Wa	is an 24h	. Were autopsy findings available
Records,	The lav	Completed				aut	opsy formed?	prior to completion of cause of death?
Vital		Ö	25. Was case referred to medical			1 ☐ Yes		1 ☐ Yes 2 ☐ No
⋚		O B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	Other	6. Place of Death (Check only		- Alaine
of		H	27. Manner of Death	28a. Date of Injury 28b. T	patient 3 LDOA	4 Nursing Home 5 He	sidence 6 MO	ther (Specify)
Division	ding f th. After funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) In	ime of 28c. Injury at jury Work? M 1 ☐ Yes	s 2 No		
S	Attandi death. ctor: A y the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, far			(Street and Num	nber or Rural Route Number.
Ω	i or Attand after death Diractor: /	Certification:	4 Homicide	building, etc. (Specify)	, , ,		own, State)	,
	ospitai or A hours after unaral Dirac ly filled in by		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	death occurred at the time.	date and place, and due to th	e cause(s) and n	nanner as stated.
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	edical	(Check only 2 Medical Examination)	ner: On the basis of examination and and manner stated.	Vor investigation, in my opini	ion, death occurred at the time	e, date and place	e, and due to the cause(s)
	To th within Fo th	Me	29b. Signature and title of certifier	1 1	29c. License n	umber	29d. Date sign	ed (Month, Day, Year)
	- > - 0		1 Anth	my let.	m1 125	205	nation	h1,2005
•	96		30. Name ind address of person who co	mple ed cause of death life 23a) (Type, Print)			
	2		W. A. Riley	63MC 670	1 N. Cha	· Cos St Ba	lto inc	4 21203
	Sta	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature				
	Regist		MAR 0 8 200	5 Bene &	Societies.			
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ORIGINAL

MARCH 1, 8005 BYTHIN

BLACKWEII, EDWARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene) \(\cap \cap \cap \) 07608 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March LENITHER COLLINS 03 2005 3:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical Center N/A Baltimore 8. Date of Birth (Month, Day, Year) Sept 7, 1971 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 33 Months 1 M 2 □ F **Director** 218-76-2725 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Items 23a or 28a-f ahow vent, the Medical Examinar must be notified at 1 Yes 2 No BALTIMORE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22 U.S. A NS 238 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify BLACK If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Compl Elementary/Secondary (0-12) College (1-4or 5+) PAINTER MAINTENANCE 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be STHONG COLLINS HARles SAM JOAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: 9 Department of Health ar Important: If item 27 Is any injury or other trau once. BALTO. MD 1711 WILKENS NIKESHA Strong-Sisler 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3-11-05 Lion BAITO 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fun, Suo. IA Michael Zigliet Fun, Suo. IA Bo, Box 67338 BAHO. I 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Complications of grashot wounds /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes SENo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ ✓ es 2 □ No 24a. Was an autopsy performed? 1 Yes 2□No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1X Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 5 Pending investigation 1 Natural 1 Yes No after death. 12/9/1995 6:49 P subject shot 2 Accident the 6 Could not be determined Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Route Number, City or Town, State) 3400 blk Reisterstown 4 XHomicide filled in by street Road Baltimore, MD within 24 hours a To tha Funeral E To tha Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier OCME rense asha MD March 04, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Treenberg 111 Penn Street Baltimore, Maryland 21201 asha

Registrar

31. Date filed (Month, Day, Year) MAR 0 8 2005 32. Registrar's Spnature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2005 March 11:45 A M Geraldine Crisp /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kingsville Baltimore 4 Jerusalem Glen Court 8. Date of Birth (Month, Day, Year) Sept. 14,1934 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 70 213-30-5979 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. tnside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. snt: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic avant, If a Medical Examinar must be notified at 1 XYes 2 □ No Director Maruland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 508 Umbra Street 21224 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No tf Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status t Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Kowalewski Tillie Kupidlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Jerusalem Glen Ct., Kingsville, MD 21087 Mr. Kenneth Crisp (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of P Important: If ite any injury or ot once. Holu Rosary Cemetery 3/4/2005 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) METASTATIC MONTHS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): P.O. Box 68760, use as IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year for Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed) page 1 Yes 2 No 1 ☐ Yes 2 ☐ No uneral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AOther (Specific Source examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an address of parson who completed cause of peath (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 10:55 PM March Co, 2005 Mor Cross /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Hone Westminster Nursing Westmin ster Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F 85 Yrs. Maryland Director 220-34-3736 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Pagas 1 and 2 should be filad within 72 hours after death with tha Manylar nent of Haalib and Mantal Hygians.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is biodical Examine must be notified at ury or other traumatic event, it is biodical Examine must be notified at 1 ☐ Yes 2 No Directo Maryland Carol1 Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 751 Gist Rd. 21157 United States Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: White Baltimore, Maryland 21215-0020 Specify. ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nations Bank Banking 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard Oliver Hutchins, Sr. Carrie Lee Musgrove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 751 Gist Rd. Westminster, MD 21157 Stephen Haugh (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dapartment of important: If its any injury or o 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Morgan Chapel Cem. 3/11/2005 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 21. Signature of Funeral Service License. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 4 weeks Examiner Due to (or as a conseque nce of): Physician/Medical Examiner usa as tha burial-transit or Attending Physician: Tha law raquires that the daath cartificete be exacted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ceta has baan siç , page 2 should b this certificeta has 1 Ves 21/NU 1 ☐ Yes 2 ☐ No the funaral diractor. 26. Plage of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2☑ No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Aftar 5 Pending investigation To the Hospital or Attending within 24 hours eftar daath.
To the Funeral Director: Afta complataly filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00059943 7, 200,5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Stoner lown C. Awel Mo Suite 307 westminster 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 08 2005 Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State	of Mar	yland / [•	rtment of H		ind M	-	giene Reg. No.	200	5	07613	2
			1. Decedent's Name (First,	Middle, La	st)							2. Date of De	ath Day	· Y	ear	3. Time of Death	
	Physici /Medic		Mary Eliza	abeth	Cole							March	-	005		4:20 PN	I
	Examin		4a. Facility Name (If not ins			umber)			4b. City, Town, or	Location of	f Death		4c.	County of I	Death		
			407 Gralar						Catonsvi		34 U T			Balti			_
U	Funeral		5. Social Security Number	6. S	Sex □M 2.53tF	7. Age (1	In yrs. last bii	thday)	If Under 1 Year Months Days	If Under:	Min.	8. Date of Bir (Month, Da	y, Year)		Coun		п
	Director		220-84-7515 Usual Residence of Deced			43						April	5, 1	961	Mar	yland	_
	land ow			County		1	0c. City, Tow	n or Lo	cation						1	0d. Inside City Limits	ŝ
	Many Fish	to	Maryland I	3altim	ore		Cato	nsv	ille						ŀ	1 ☐ Yes 2 No)
	r 28e	Director	10e. Street and Number						10f. Zip Code		***		10g. Citi	zen of Wha	t Coun	try?	
	23e c		407 Gralan	Road					21228				U	SA			
	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Items 23e or 28e-f show ant, the Medical Examinar must be redified at	Funeral	11. Marital Status		12. Was De	cedent Eve	er in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Ori	gin? (Spe Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Black,			
9	or It	by Fu	1 Never Married 2		If Yes, G	2 [X]No ≧ive			☐ Yes 22 No	Specify:				Specify: V			
Ö	hours tural	d b	3 Widowed 4 Di		Year or	Dates:	169	Decer	lent's Usual Occupa	ation.			16b Kir	nd of Busir	ace/lnc	fuetn	_
7	in 72 in mai	olete	(Specify only		ade completed			(Give	kind of work done d DO NOT use retired,	lurina mosi	of workir	ng	100.10	ila oi basii	1000/1110	lustry	
7	I with	Completed	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		Но	memaker				Ow	n Hon	ıe		
Maryland 21215-0036	e filec I Hyg othe	Be C	17. Father's Name (First, A	Middle, Last,)					18. Mothe	r's Name	(First, Middle,	Maiden	Surname)			
<u>a</u>	uld be Aenta rrked tic ev	TO E	Charles Coal	clev K	reis					Mary	Eli2	zabeth	Wiem	an			
ary	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 Is marked other then "netural", or items 23e or 28e-f show other treumatic event. If a Medical Examinar must be ruillied at		19a. Informant's Name/Re	elationship (Type, Print)		198	o. Mailin	g Address (Street a						ite, Zip	Code)	
	and and a salth	- 8	Steve Cole_		H	usban			Gralan Ro	oad;							
ore	Pages 1 nent of H ont: If ite		20a. Method of Disposition 1 ☑Burial 2 ☐ Cren		Removal fror	n State	cemete	ry, cren	sition (Name of natory or other place			ate		cation - Cit			
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		`4 □Donation 5 □O				New C		edral Cem			9/05	ватт	ımore	, M	aryland	
Bal	Depariment Department of the poores.		21. Signature of Euneral S	Service Licer	nsee	40.4	0.201		Sterling	2 Ash	ton S	Schwab	Fune	ral H	lome	, Inc.	
			23a Part 1 Enter the dise	ase, or com	polications that		0/290 le death. Do		/36 Edmo	ondso:	n Ave	enue; C	aton	svill	e.	MD 21228 Approximate	
			23a. Part1. Enter the dise shock, or heaft failur Immediate Cause (Final	e. List only								50				Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	-	a. Add	LINGCO	consequence	nca_	of appe	ndic	(6)	onta	co		-	3912	
В	Examiner				Due (0 (01 a5 a 0	consequence	OI).									
	1	je.	Sequentially list conditions cause. Enter Underlying Cause (Disease or injury	s,	b. Due t	o or as a	consiguence	of):									
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	1	c.												
o,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	EX	resulting in death) Last		Due t	o (or as a o	consequence	of):									
8760,	ate be nysici he bu	dical			_ d												
9	artifica ing pl	Med	IF FEMALE:	1.7													
Вох	that the death certificed by the attending properties as	Physician/Me	23b. Was decedent pregn in the past 12 month			birth 2	Fetal death		Ectopic pregnancy				2	23d. Date o Month		ry Day Year	
0	the a	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9□ Unk		ne of death	2	Other (specify)								
<u>α</u>	res that the signed by be detacted	/ Ph	Part II. Other significant of	conditions	contributing to	death but	nat resulting	in the u	nderlying cause give	en in Part I		23e. Did t	obacco u	ise contribu	ite to th	e cause of death?	
ds,	uires sign ld be	d by										1 🗆	Yes 2-	⊒ ₩0 3(] Prob	ably 4 □Unknowr	1
COL	w requir been si should	lete										24a. Was	an	24b. We	re auto	osy findings available	a
Re	The lav	Completed											osy ormed?	dea	th?	npletion of cause of	
Vital Records,		a)	25. Was case referred to	medical	T					26. Place	of Death	(Check only			103	20110	
	Physicien: r this certific ral director,	To B	examiner?		Hospital: 1 [] Inpatient	2 🗆 ER/O	utpatien	t 3 DOA Othe	er: 4 🗌 Nu	rsing Hor	me 5 Resi	dence (6 Other	Specify	<i>'</i>)	
o c	ding Ph n. After th funeral		27. Manner of Death	Pending		te of Injury onth, Day		Time of	28c. Injury Work		2	28d. Describe	how injur	y occurred			
<u>0</u>	Attending r death. ector: After by the fune	atle	2 Accident	investigatio	n				M 1 []	Yes 2	-						
Division	after de Directa	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	288. Pla	ce of Injury Iding, etc.		arm, str	eet, factory, office		2	28f. Location (City or To			or Rura	l Route Number,	
	urs af		20 0 15		<u> </u>						4-1					-1.1	_
	Hosi 24 ho Fund Fund Itely f	edical	29a. Certifier 1 0 0 (Check only 2 N one)	ledical Exe	miner: On the	ne best of basis of e	my knowledg xamination al	nd/or in	n occurred at the time vestigation, in my op	oinion, dea	th occurre	ed at the time,	date and	and mann place, and	due to	the cause(s)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Med	29b. Signature and title of	certifier					29c. License	number			29d. Dat	e signed (/	Aonth,	Day, Year)	_
)	⊢≯⊢ŏ		1	W	an				Du	124	3		Ma	rch 8	, 2	2005	
,	d		30. Name and address of	person who	completed ca	use of dea	ith (Item 23a)	(Туре,	Print)		_	-					
7)		JWOCK	IUM	S	1120	N.R	elli	2 Raco	(C	Ams	rille	m	2 C	12	28	
Ì	Sta		31. Date filed (Month, Day	y, Year)	32.	Registrar'	s Signature	-	Cartes								
	Regist	rar	MA	R 08	2005	Mary	מאק עו	1	29c. License O 4 C Print)	- 55	3.						_

			. For	State of Ma	ryland / Depa			•	-	. 07610
		•	1 - State Registrar		Cei	rtificate of	Death	Re	g. No.	0 0/613
	Dhysici		1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat Month	h Day Yea	3. Time of Death
	Physici /Medic			Macie	0. C	arter		2	28 2005	8:46p.M
Н	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of D	
			Ridgeway Manor 5. Social Security Number 6. Social Security Number 8.		(In yrs. last birthday)	Catons If Under 1 Year	SV111e	8. Date of Birth		imore Birthplace (State or Foreign
	Funeral Director			□M 21X7F	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 3-7-1		Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent						724	
	show	_	10a. State 10b. County		Baltimo					10d. Inside City Limits 1 1 Yes 2 □ No
	he M	ectc	MD NA 10e. Street and Number		Baltimo	10f. Zip Code		11	Og. Citizen of What	
	with with	급	2300 Terra Fima	Road An	+ B=2		1225	, ,		Country
	death	Funeral Director	11. Marital Status	12. Was Decedent E		1	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - A	merica <i>n</i> Indian,
9	after or ita	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	0	ii Yes, specify Cut 1 ☐ Yes 2 X ☐ No		Hican, etc.)		hite, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or itams 23e or 28e-f show sither than "helical Examinat must be redified at	d by	3 ₩Widowed 4 □Divorced	Year or Dates:					Specify: B	
ν.	"natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Busine	ss/Industry
2121	withir ene. than	ошо	Elementary/Secondary (0-12) 12th grade	College (1-4or 54	-)	Aide	50)		Rehab.	Conton
2	Hygi other ant, I	Be C	17. Father's Name (First, Middle, Last)			AIGE	18. Mother's Name			Center
lan	uld be denta rked tic ev	To B	Aaron Owens				Evelyn	Colema	n	
Maryland	short and M is ma		19a. Informant's Name/Relationship (Турө, Print)	19b. Mailir	ng Address (Stree	t and Number or Run	al Route Number,	City or Town, Stat	e, Zip Code) 21225
	and 2 ealth m 27		Norma Cole-Daug	ghter			Fima, Ro	_		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if itam 27 is marked other than "natural; or itams 23e or 28e-f show any nivery or other traumatic evant, the Medical Evantment must be neithed at ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crei	natory or other pla	ace)	Date 2	20c. Location - City	or Town, State
≣	t. Partmen		`4 ☐ Donation 5 ☐ Other (Specify	v)		morial 2. Name and Addr	Park 3/		Randall	stown, Md
Ba	permi Depa Impo eny ii		21. Signature of Funeral Service Licer	Im and		4300	Wabash Av	arch F/H	West	1215
	Su miles	- 22	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Conf	and we	Heart	- faile	ino		Onset and Death
	/Medical		resulting in death)	a Due to (or x; a	consequence of):	., -	1	0 40		50- 4
	Examiner		Sequentially list conditions,	b	1172					79.
	sit ad	lhei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760,	te be executed ysician and e burial-transit	alE		d						
189	leath certificate attending phy: I for use as the	edlo							1	
Вох	h cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnanc	cv		23d. Date of	,
<u>.</u>	the att	Physician/Medl	in the past 12 months? 1 Yes 2 No	4□Pregnant at t 9□Unknown		Other (specify)	-,		Month	Day Year
P.O.	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderwing cause o	oven in Part I	23e Did toh	acco use coarbut	e to the cause of death?
	Se un equ	d by	C'		recent		ivori ir i asci,	1 □ Ye		Probably 4 Unknown
Sor	w require been si should l	ete		7		•		24a. Was a	24h Were	autopsy findings available
Re	icien: The lav certificate has ector, page 2	Completed						autops perforn	y prior ned? death	to completion of cause of 1?
ta	en: T tificati tor, pa	a	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2		/es 2□No
<u> </u>	Physicial this certail direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗌 Inpatier	nt 2 ER/Outpatier	nt 3 DOA	than	And the second	nce 6 Other (5	Specify)
0 0	Attanding Physicien: r death. actor: After this certifici by the funeral director.		27. Manner of Death 1 DNatural 5 Dending	28a. Date of Injury (Month, Day	Year) 28b. Time o	W	ork?	28d. Describe ho	w injury occurred	
sio	uttandi death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not b				☐Yes 2☐No	00(
Division of Vital Records,	l or Attand after death Diractor:	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, sti . (Specify)	reet, factory, office	9	City or Town		Rural Route Number,
	To the Hospital or Attanding Physicien: The within 24 hours after death. To the Funaral Director. After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge, deat	h occurred at the	time, date and place.	and due to the ca	iuse(s) and manne	r as stated.
	ne Ho n 24 h ne Fu	edical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	ted.	/1				
	To the To the Comp	Σ	29b. Signature and title of certifier	Livi	17then	CL 29c. Licer	nse number	2	9d. Date signed (M	onth, Day, Year)
}	6		Much	-J .	, ,	7) 1	15674	4	- ware	-, 2005
	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	22) Cat	ag sill	My 2	onth, Day, Year) 2, '2 0 0 5
	Sta	ite	31. Date filed (Manth Pay, Year)	3 Registra	r's Signature	1447	J. 017	-		
* \	Regist		MAK U O Z	U)	No April	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Lillie Mae Coleman 03 March 2005 04:50 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre De Grace
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M XX X F Months Days Hours Min Yrs. Director 097-14-6240 83 NC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h Counts 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Harford Belair 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 410 East MacPhail Road 21014 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Nursing Assistant Keswick Nursing Home na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental la markad 2 John H. Phillips Alean Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health itam 27 I 912 Falling Stone Ct., Belair, Md Dianna Tucker-Daughter 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o once. 1 ▼ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Department Garrison Forest Vet. 3/14/05 Owings Mill, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee Edmond 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 aulu **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to or as a consequence of): Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 Yes 2 No 3 Probably 4 Woknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗆 No 1 ☐ Yes 1 Yes Division of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident Diractor 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours af To the Funaral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03 03 2005

State Registrar 1308

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

#102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 8 2005

2. Registrar's Signature

			1 = Stata Ragistrar	State of Maryla	-	artment of H			ene) () 5	07615
	Physici	an	1. Decedent's Name (First, Middle, Last) CLINTON J	CHESTER				2. Date of Death Month MARCH		
	/Medio		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea		4c. County of De	4:55 P M
	LXumm		400 MILLINGTON	AVE, APT.	#201	BALTIM	ORE CI		N/A	
	Funeral Director		217-40-8493	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) (irthplace (State or Foreign Country) ARYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	ath with the Marylar s 23a or 28a-f show ust 2e notified at	ctor	MD N/A		В	ALTIMORE	CITY			Y∰Yes 2□No
	ith the	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What 0	Country?
	eath w	erai	400 MILLINGTON	AVE., APT.			223	Specify Vas or No-	USA 14. Race - An	nerican Indian
39	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show Tre Madical Examiner must be notified at	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ※ Divorced	Amed Forces? **Mode of the control	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	rto Rican, etc.)	Black, Wh	
15-0036	72 hou natura Ical E		15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa kind of work done of	ation	ndking 1	6b. Kind of Busines	s/Industry
21	rithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			
N	filed within the Hygiene. other than rent, the M	e Col	12TH 17. Father's Name (First, Middle, Last)		SANTI	VATION W		me (First, Middle, M		BALTIMORE
⊆	g & 2 9	To Be	JOHN CHESTER				DOROT		SNEAD	
Mar	Tra T		19a. Informant's Name/Relationship (Ty) AIKO CAREY / SI	oe, Print) STER				Rura <i>l Route Number,</i> E , BALTI		
	es 1 and 3 of Health of Item 27 or other tr		20a. Method of Disposition	20b.	Place of Dispo	esition (Name of matory or other place			Oc. Location - City of	
	Pages ment of tant: If it lury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)			REMATORY			'ATONSVI	
Ball	permit. Page Department Important: If any injury o		21. Signature of Funeral Service License	· Nown						OME 21207 IMORE, MD
			23a. Mar. Enter the disease, or compli shock or heart failure. List only or	cations that caused the dece e cause on ear line.	ath. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Co	Roma	by on	tey (disons		Onset and Death
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-	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonse	quence of):	n U	E na 1			
	rate be executed hysician and the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a co se	equence of):	ok dr	h was	Ö		
8760	sate be shysicia the buri	dicail		150	hemi	Ca	odisc	1. Joseph		
89 ×	ertifica ling ph	Med	IF FEMALE:	7- 16						
O. Box	e death certific he attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal déath 3 [Ectopic pregnancy Other <i>(specify)</i>			23d. Date of do Month	elivery Day Year
٠.	res that the de signed by the a be detached t	/ Phy	Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Vital Records,	The law requires that the ite has been signed by th page 2 should be detache	ed by						1 ☐ Yes	s 2□No 3□F	Probably 4 Renknown
ဝင္ပ	law re as bee 2 sho	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
								perform 1 ☐ Yes 2	ed? death?	s 25 110
<u> </u>	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 11 Yes 2 □ No	ospital:	☐ ER/Outpatier	nt 3 DOA Othe		eath <i>(Check only one</i> Home X Pesider		a=16.1
on of	ding Phys h. After this funeral dii	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	at	28d. Describe how		в спу)
Division of	al or Attendir s atter death. Il Director: Af id in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str ify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
_	To the Hospital or Attending Physician: within 24 hours atter death. To the Funeral Director: After this certific completely tilled in by the funeral director,	edical C		sician: To the best of my known the side of the basis of examinand manner stated.						
	To the within To the comple	Me	29b. Signature and title of certifier	0-100		29c. License			d. Date signed (Mor	1
			-	& Man		1	6061	15	3/3	105
	X		30. Name and address of person who co	em.		Print) Lefo	19 Pall	hs Road	BOUN	105 MRE MO 21211
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 200	Registrar's Sign	nature	25				

			1 - For State Registrar	State of M	-			ind M	, ,	21	005	07616
	Dhysisi		1. Decedent's Name (First, Middle, La.	st)							Voor	3. Time of Death
	/Medio								MARCH	7,	2005	6:40 a M
	Examir	ier)		Cate of Death Reg. No. 0 5 7 1 1 1 1 1 1 1 1 1					
		*			an //a usa in at histoday.					Ва		
н	Funeral Director	Developer's Name (Frist, Middle, Last)		9. Birthp	elace (State or Foreign etry)							
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	urylan show	_	10a. State 10b. County		10c. City, Town or Lo	ocation					1	Od. Inside City Limits
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"	fter d	F		Armed Forces	No I			Puerto	Rican, etc.)			
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21215-0036	72 hours after death with the Maryland Instural', or Items 23a or 28a-1 show disal Examinat must be rodified at	etec			16a. Dece	dent's Usual Occup	ation	of worki	ing.	16b. Kind of	Business/Ind	dustry
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	filled v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)		HOIII	emaker	18 Mother	re Name	/First Middle A			
an	ld be ental ked o	o B									amo,	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be rollified at	-			19b. Maili	ng Address (Street	and Number	r or Rura	I Route Number,	City or Tow	n, State, Zip	Code)
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ore	<u> </u>			Removal from State	cemetery, crei	natory or other place	ce)			20c. Location	n - City or To	wn, State
Baltimore,	Pag ment tant: jury c		`4 ☐ Donation 5 ☐ Other (Specify	/)	St. Mary		- 1				ott Ci	ity, MD
Bal	permit. Pages 1 and Deportment of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licer	The Oma	W 25	Macnabb ^{oor} f	unera.	1 Ho	me, P.A.			
	_		23a. Part1. Enter the disease, or com	DONATO	d the death. Do not ent	SUL Frede er the mode of dvir	erick I	Road	Catons	sville	, MD 2	
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Ö	w requir been si should	etec	01110010	1,410	22/ / 300							
Vital Records,	has ge 2	mpi							autopsy	,	prior to com	ssy findings available apletion of cause of
ā	ificate or, pa		25 Was case referred to medical				00 81		1 ☐ Yes 2	⊠ No		2□ No
N N	Physician: this certific ral director,	8	examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	t 3 DOA Oth					ther (Specific)
J of	ng Ph ter th		'A. A'	28a. Date of Inju	ury 28b. Time of	28c. Injun	y at					/
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Division	after d Direct Jin by	Hit		286. Place of in	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		2	28f. Location (Stre City or Town,	eet and Num State)	ber or Rural	Route Number,
	pital ours a eral (29a Cartifiar 1X Cartifying Ph	veicien: To the best	of my knowledge, death			-1				
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Attenthis certificate ha completely filled in by the funeral director, page	edice	Check only 2 Medical Exen	liner: On the basis of	of examination and/or inv	estigation, in my o	pinion, death	occurre	ed at the time, dat	use(s) and n te and place	anner as sta , and due to	the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	0			_			d. Date sign	ed (Month, D	Day, Year)
•			Lelo				635	4	M	ARCH	7,2	2005
	3		30. Name and address of person who E W COLE	completed cause of $AGNE$	death (Item 23a) (Type, S 900 (Print) ATON A	WE	BA	LT. Mi). ₂	1229	7
•	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 20		rar's Signature	e Me						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene |- State Regi**SMFND ITEM #17 PER FH G841 3/1C** edificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month RUTH KIZER ATWELL COLSTON 2065 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROSE JA/E HOSPITA BALLIMERE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2√F Yrs Director 226-09-9693 91 Jan 12, 1914 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 8832 Walther Blvd 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: ō 1 ☐ Yes 2 ▼ No Specify: White 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Engineering Dept 2 yrs Administrative Assistant 17. Father's Name (First, Middle, Last) SAMUEL RUSSELL ATWELL Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Is marked 2 Atwooll Samuel Russell Atwell Carrie Perkins Barr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 4235 E. Joppa Road, Baltimore, Maryland 21236 Brenda C. Lipinski (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) 3/8/2005 Mt. Hebron Cemetery Winchester, Vir inia 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Martin D. Dawson auson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Subdukal disease or condition resulting in death) 12 Hours /Medical Due to (or as a consequence of): Examiner 24 Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant. 1 Live birth 2 Fetal dea: 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 2 KNO or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Accident 1 ☐ Yes 2 XNo investigation -2005 11:00 PM after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State) \$ \$00 er or Hural Route Number, COWALTHER BLVD à 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a

To the Funeral Completely filled 29a. Certifier (Check only one) 29b. Signature and title of centier 29c. License number 29d. Date signed (Month, Day, Year) DO056296 514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEWARE DR. DR. JASON BIRNBAUM 9000 FRANKLI BAITIMOIZE My 21237 31. Date filed (Month, Day, Year) MAR 0 8 2005 Registrar

			For State	ate of Marylan	d / Depa			d Mental Hy	giene nn	5 07518
	_		Registrar		Cei	rtificate of	Death	2. Date of De	Reg. No.	0 0 1 0 1 0
	Physicia	an	1. Decedent's Name (First, Middle, Last)			COUEN	r.	Month	Day Y	3. Time of Death
	/Medic Examin		MILDRED 4a. Facility Name (If not institution, give street	and number)		COHEN 4b. City. Town.	or Location of D	MARCH	5 200 4c. County of	0 10.00
	Examin	er	SUNRISE OF PIKESVILL			PIKESV				TIMORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea Months Days		Hrs. 8. Date of Bi	th g	. Birthplace (State or Foreign Country)
	Director		104-12-240/	2LX F 8!	Yrs.	Wortens Days	Tiodis	02/15/	1920	PA
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	/, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 she	tor	MD BALTIMORE	PII	KESVIL	LE				1 ☐ Yes 2 🏹 No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	th wit	alD	3800 OLD COURT ROAD)		21208			U.S.A	•
	tems tems	nue	A	/as Decedent Ever in U. med Forces?	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	rs afte	y F	- X If	Yes 2 1 No Yes, Give ear or Dates:	- 1	1 □ Yes 2 💆 No			Specify:	WHITE
9	be filad within 72 hours after death with the Maryland Hygiene. Hygiene. ad other than "natural", or Items 23a or 28a-f show ad other than "natural", or Items 23a or 28a-f show event, the Mcolcal Examiner must be notified at	Completed by	15. Decedent's Education		16a. Dece	dent's Usual Occi	upation		16b. Kind of Busi	ness/Industry
215	hin 7:	pie	(Specify only highest grade con Elementary/Secondary (0-12)	opleted) College (1-4or 5+)	(Give life.	kind of work don DO NOT use retir	e during most of ed)	working		•
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and	be fill htal H ad oth	Be	17. Father's Name (First, Middle, Last)		200050	CMITH		Name (First, Middle	, Maiden Sumame)	DDODY
Maryland 21215-0036	should by nd Menta i marked imatic ev	٥	MORRIS 19a. Informant's Name/Relationship (Type, F		COOPER		BESSI	L or Rural Route Numb	ner City or Town St	BRODY
	nd 2 s lith ar 27 is r trau		MARK COHEN / SON	,		DEER CRE		ARNOLD,		aro, 21p 0000)
re,	of Hea item other		20a. Method of Disposition		lace of Dispo	osition (Name of matory or other pi	!	Date	20c. Location - Ci	ty or Town, State
Ë	Pagas nant of I ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ♠ Remore • 4 ☐ Donation 5 ☐ Other (Specify)	Val from State SHA	LOM ME	EMORIAL	PARK 0:	3/06/2005	LOWER MO	RELAND, PA
Baltimore,	permit. Pagas 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		21. Signature of Funeral Service Licensee					SOL LEVIN		
	or □ ™ ar ol		Jay Fel							E, MD 21208
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	use on each line.				raiac of respiratory a	irrest,	Approximate Interva/Between Poset and Death
	Physician /Medical		disease or condition resulting in death)	Due to for an a series		udion	yox/ai	45		unnun
	/Medical Examiner			Due to (or as a consequ	uence of):		00			
7	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conseq	uence of):					
V	and transi	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last							
,092	ite be executed hysician and he burial-transit	cai Ex	resulting in deathy cast	Due to (or as a consequence	uence of):					
687	ate ohy:		d							
Вох	death certifica e attending ph id for use as th	n/M		yes, outcome of pregna		ne			23d. Date	of delivery
	it the death certific by the attending p tached for use as	Physician/Med	in the past 12 menths? 1 □ Yes 2 ☑ No	☐Live birth 2☐Feta ☐Pregnant at time of d ☐Unknown		□Ectopic pregnan □ Other (specify)			Month	n Day Year
P.0	The law requires that the tee has been signed by thoage 2 should be detached.	Phys	9 🗆 Onknown							12.
Ś	res tha	by	Part II. Other significant conditions contribu		ulting in the u	ınderlying cause (given in Part I.			ute to the cause of death? □ Probably 4 □Unknown
orc	w require been sign should b	eted	collecti	nslon				_		
Vital Record	The law cate has I page 2 s	ompieted						24a. Was	psy pri	ere autopsy findings available or to completion of cause of ath?
tal		e Co	25. Was case referred to medical	<u> </u>			OS Diago of	1 ☐ Yes		Yes 2 No
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ιof		n: T	27. Manner of Death 28	Ba. Date of Injury (Month, Day Year)	28b. Time o	of 28c. In			how injury occurred	
Siol	Attending r death. ector: After by the fune	atic	2 Accident investigation	,			Yes 2 No			
Division	or Att	ertification;	3 Suicide 6 Could not be determined	Be. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, offic	0	28f. Location City or To	(Street and Number iwn, State)	or Rural Route Number,
Ц	a = p	O	29a. Certifier 1 Certifying Physicie	n: To the best of my kno	wledge deal	th occurred at the	time date and r	place, and due to the	Cause(s) and man	ner as stated
	spit our nere	(75	(Check only 2 Medical Exeminer:	On the basis of examina	tion and/or in	nvestigation, in my	opinion, death	occurred at the time	, date and place, an	d due to the cause(s)
	ne Hospital 24 hours a na Funeral (edica	one) 2 medical Exeminer:	and mariner states.						
	To the Hospital or Attentwithin 24 hours after deating the Funeral Director: completely filled in by the	Medicai	29b. Signature and title of Certifier	Mo		29c. Lice	nse number	CIB	29d. Date signed (Month, Day, Year)
)	To the Hospit within 24 hours To the Funers completely fille	Medica	one)	mn		29c. Lice	D27	569	29d. Date signed (Month, Day, Year)
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	35	Σ	29b. Signature and title of certified	mn	n	29c. Lice	D27	569 me T.	29d. Date signed (246/6	Month, Day, Year)
:	To the Hospit Within 24 hour To the Funers To the Funers Completely fills		29b. Signature and title of certified 30. Name and address of person who demonstrates the second se	grediction of death (Iten and	n	29c. Lice	D27	569 me T.	29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 0.0 5

		•	1- State Amend Item 1	2 per fh G	yland / De 841 3-16	partment of F 2-05 tas entificate of	lealth and M <i>Death</i>	lental Hyg Re	ieņe 🛮 🕕 eg. No.	5	07619
	Dhusisi		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		Thomas Geor	ge Carkhuf	f			March 3		005	6:00 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Death		4c. County	of Death	
			Laurel Regional	Hospital		Larue			Princ	e Geo	orge's
	Funeral		5. Social Security Number 6. Se	x 7. Age (i	In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
	Director		179-14-3378	Х	81 Yrs	5.		Aug. 12	1923	Penns	sylvania
	land		10a. State 10b. County	1	Oc. City, Town o	r Location				1	0d. Inside City Limits
	Mary f sh	Ö	MD Prince G	eorge's	Laur	-e1					1 ☐ Yes 2 ☐ No
	the routi	rec	10e. Street and Number	00290 2		10f. Zip Code		10	0g. Citizen of V	Vhat Cour	
	h with	Funeral Director	1016 Harrison Dr	ive		207	0.7		USA		
	deati	ner	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	14. Rac		can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational perceitled at once.	by	1 Never Married 2 🕅 Married 3 Widowed 4 Divorced	Armed Forces? Y Yes 2 Yes If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☐ No	Specify:	rican, etc.)	Specify	k, White, ∵ Wl	etc. nite
Š Q	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. D	ecedent's Usual Occup	ation	ina	16b. Kind of Bu	ısiness/Ind	dustry
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gu	be fil Ital H od otl	Be	17. Father's Name (First, Middle, Last)	5.5			18. Mother's Name			10)	
3	Jould J Mer narke	^C	George R. Carkh		101.0			a R. Roc			
Maryland	d 2 st		19a. Informant's Name/Relationship (T)			lailing Address (Street					(Code)
	1 an Heall em 2		Carol Carkhuff / 20a. Method of Disposition) 16 Harriso isposition (Name of crematory or other plac			MD 20 20c. Location -	707 City or To	own State
o I	ages ant of t: If if		1 Burial 2 Cremation 3 F 1 Other (Specify,	Hemovai from State	_	crematory or other plac 1001n Cem.					
Baltimore,	nit. F artme ortan injur		21. Signature of Funeral Service Licens		rt. LII	22. Name and Addre			Brentwo Euneral		
ñ	Depa Impo any ii		1 Golden	M00	0770	313 Talbo				20707	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	e death. Do not	enter the mode of dyin	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of)						
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	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		in echeupeanus						0.0
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89	tificate ig phy as the	edicai		u							
Вох	h cerd endin	M/u	230. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		3 Ectopic pregnancy			23d. Dat	e of delive	ery
8	that the death cer ed by the attendin detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at tin		5 Other (specify)	·	·	Moi	nth	Day Year
P.O.	The law requires that the tite has been signed by thoage 2 should be detache	Phy	9 Unknown								
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ord	w require been si should I	ted	Chronic Obstruc	tive Pulmor	nary Dis	sease		1 Ve	s 2 No	3X Prob	ably 4 Unknown
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al F		S						perform 1 ☐ Yes 2		leath?	2 No
Vital		Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death				
of		. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2X ER/Outpa 28b. Tim		er: 4 Nursing Ho	me 5 Reside 28d. Describe ho			γ)
on	Attending Is a death. ector: After by the funer	ertification;	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	/ear) Inju	iry Wor	k? Yes 2 □No		w injury occur	00	
Division	l or Atten after deatl Director:	fica	3 Suicide 6 Could not be	286. Place of injury	/ - At home, farm	, street, factory, office		28f. Location (St	reet and Numb	er or Rura	I Route Number,
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	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 ☐ Certifying Phy (Check only one)	vsician: To the best of iner: On the basis of example and manner state	xamination and/o	leath occurred at the tir or investigation, in my o	ne, date and place, pinion, death occurr	and due to the ca	ause(s) and ma ate and place, a	inner as st and due to	tated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	7/	/	29c. Licens	e number	25	9d. Date signed	(Month,	Day, Year)
			1/Wh/ a	lus Th	6	D240	93		March :	3, 20	005
	11		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Ty						
	19		Mark Parkhurst	T		vis Avenue	, 200, R	iverdale	e, MD 20	0737	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 8 20	32, Figistrar's	s Signature	Sparke					

			1 - State Registrar	State of Maryland / I	Department of Hea Certificate of De	ilth and Me ath		ne2 0 0	5 07620
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death	Day Ye	3. Time of Death
	/Medic	al	OLIVER LEE 4a. Facility Name (If not institution, give s		4. 65. 7		ARCH	6 200	5 3125 PM
	Examin	er	_	Extended live C	4b. City, Town, or Local			4c. County of D	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	nthday) If Under 1 Year If U		Date of Birth (Month, Day, Y		Birthplace (State or Foreign
	Director		220 -12 - /906 18 Usual Residence of Decedent	M 2□F 74	Yrs.	/	2-20-	1930 14	aryland
	yland now		10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
	Ba-f si	ctor	hed N/A	Bal	h'more				1 DeYes 2 □ No
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show he Medical Exercitar roust be rodified at	Funeral Director	10e. Street and Number		10f. Zip Code 2/2/7		10g	Citizen of What	
	death ms 23	nerai	1601 > pray Ct	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specif	y Yes or No-	14. Race - A	merican Indian,
9	or Ite	Für	1 Never Married 2 Married	Armed Forces? 1V2) Yes 2 □ No If Yes, Give		lexican, Puerto Ric pecify:	án, etc.)	Black, V	/hite, etc.
21215-0036	hours tural',	ed by	3 ₩ Widowed 4 Divorced	Year or Dates:					slack
75	n "na"	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	 Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 	g most of working	16	b. Kind of Busine	ess/Industry
21,	ed with /giene ier tha t, the	Com	7	College (1-4or 5+)		1er		Waste	Management
Maryland	be file	Be	17. Father's Name (First, Middle, Last)	0/		Mother's Name (F	4		
Z	should nd Men marka matic	ဥ	19a. Informant's Name/Relationship (Ty)	pa. Print) 191	p. Mailing Address (Street and I	nn/e	MOrks	L / J	te Zin Code)
_	alth ar 27 is ar trau		Irvin Chaner		310 W. Roge	rs Ane		, bd . 2	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	of Disposition (Name of ory, crematory or other place)	Dat	9 20	c. Location - City	or Town, State
ij	Pant ury		`4 ☐ Donation 5 ☐ Other (Specify)	Garri	son Forest UEFC	-		Buffor	led.
Bai	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service License	1	2a Name and Address of	Flyngh	is fu	negal ys.	energe P.A.
			23a. Part1. Enter the disease, or compli	cations that caused the death. Do	not enter the mode of dying, su	uch as cardiac or r	espiratory arrest	VOV NE	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	/	una Cance	0			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence		7			
	Laminer	-	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence	of):				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Cause Cause) that initiated events		3.,.				
oʻ	cate be executed obysician and the burial-transit	Еха	resulting in death) Last	Due to (or as a consequence	of):				
8760,	cate be executed ohysician and the burial-transIt	dical		i,					
9 x c	eath certific attending p I for use as I	Physician/Me	JF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	-			23d. Date of	delivery
. Box	death e atter	lciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	n 3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
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	The law requires that the death certifi tte has been signed by the attending I page 2 should be detached for use as	þ	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in	Part I.			e to the cause of death? Probably 4 Minknown
Records,	w requir been si should l	Completed					24a. Was an		
Re	The tavate has	ошо					autopsy performe	d2 prior deati	
Vital		BeC	25. Was case referred to medical examiner?		26.	Place of Death (No 1□`	res 2. No
of <	Physician: this certific ral director,	유	1 □ Yes 2 ☑ No	lospital: 1 Impatient 2 ER/O	utpatient 3 DOA Other: 4	I ☐ Nursing Home			Specify)
on o	ding F h. After funera	tion;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Time of 28c. Injury at 1 ☐ Yes		d. Describe how	injury occurred	
Division	Attender deat	ifica	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)			. Location (Stree	et and Number o	r Rural Route Number,
ā	rs afte	Certification;	4 Homicide determined	building, etc. (Specify)			City or Town, S	State)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral direction.	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examil	sician: To the best of my knowledg ner: On the basis of examination at and manner stated.	e, death occurred at the time, dand/or investigation, in my opinion	ate and place, and n, death occurred	due to the caus at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	n	29c. License nur		29d	. Date signed (M	onth, Day, Year)
}			In O	Cy 10	2572	39	/	March "	12005
			30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print) when Ray EN E.	INA B.	## .	e. 2	1218
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Si Mi	, , , , ,	viii yn bi	re .	
	Registi	ar	MAR 0 8 2005	JOSEPH - LE SE					

State of Maryland / Department of Health and Mental Hygiene 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** Ruth S, Coppage 2215 M MAR CIT 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore Union Memorial Hospital 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Mar 19, 1921 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours Maryland 1 ☐ M 2 💢 F Yrs. 216-32-4188 83 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinational Leginities and once. 10a. State 10b. County 10c. City. Town or Location 1X Yes 2 □ No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 700 W. 40th Street 21211 USA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) registered nurse health 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Hammond Smith Stella Baker ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julie Fisher/granddaughter 8304 Dalesford Road Baltimore, MD 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Funeral Service Licenses Wade, Di ceetor M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial transit Due to (or as a consequence of) P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4□Pregnant at time of death detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe 1 Yes 2 No 1 🗌 Yes 2 2 No certificate To the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred funeral 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending Injury 1 Yes 2 No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in by after 4 | Homicide within 24 hours aft To the Funerel Di completely filled in 1& Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2438649 AT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MARYLAND ZIZIS 201 EAST UNIVERSITY PARKWAY AMYAD FAHD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 8 2005

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylan	-	artment of H		ind Mental H	lygien Reg. N	7 11 11	5	07622	2
			1. Decedent's Name (First, Middle,	Last)					2. Date of Month	Death		Vans	3. Time of Death	
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	÷.		532 Riviera Dr 5. Social Security Number	6. Sex		(and hinthday)	Jopp If Under 1 Year	atown		Diet	ag. Not. Day Year 2, 2005 Ac. County of Death Harford Year) 1933 Ac. County of Death Harford 9. Birthplace (State or Fore Country) 1933 Maryland 10d. Inside City Lim 1 Yes 2 1 1 1 Yes 2 1 1 1 Yes 2 1 Yes			
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	ams a	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13.	Was Decedent of H	ispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race	- Americ	an Indian,	
30	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "neturel", or Itams 23e or 28e-f show event, the Modical Eventral retrible notified at	by Fu	1 Never Married 2 Marrie 3 X Widowed 4 Divorced	ed 1 📉 Yes If Yes, G	2 □ No ive	1	1 □ Yes 2 X No	Specify:	, r donto riidani, did.,					
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Z Z	id 2 slith an Ith an traur		Mrs. Mary C. Gr		ughter)					-			Code)	
ā,	s far f Hea item		20a. Method of Disposition		20b. P		sition (Name of matory or other place		Date	_			wn, State	
Ē	Page sent o nt: If		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp		1 State		apel UMC		3/8/05	Fa1	1ston	ı. Ma	arvland	
saltimore,	permit. Pages 1 and 2 should b Department of Health and Menis Importent: If item 27 is marked any njury or other traumatic e once.		21. Signature of Furieral Service L	icensee			-							
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OF THE	Funeral		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
. 11	Director		220-07-3337 1	2 F 8	8 Yrs.	Months Days	Hours Will.	Feb 27, 1	916	Junuy) Clik
J. C	aryland show		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Loc	ation				10d. Inside City Limits
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	To ti To ti comp	ž	29b. Signature and title of certifier	Dl. in		· -	se number	29d.	Date signed (Mont	h, Day, Year)
			Childre	connecty "	· · · · · · · · · · · · · · · · · · ·		30133		2/	7/05
			30. Name and address of person who	DNNELLY	MO	rint)				
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				epartment of Health and Me Certificate of Death	ental Hygier	/11115 11/671
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Jules Max de Fries		2. Date of Death Month MARCH	3. Time of Death Day Year 4, 2005 2:35 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death		4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 222-18-5977 6. Sex 1 M 2 □ F 7. Age (In yrs. last birth. 1 M 2 □ F 75 Yr. Usual Residence of Decedent	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye october 13	9. Birthplace (State or Foreign Country) Maryland
	iryland ihow		10a. State 10b. County 10c. City, Town			10d. Inside City Limits
	the Ma 28a-f s	Director	Maryland Baltimore Baltimo	10f. Zip Code	100	1 Tes 2 No Citizen of What Country?
	th with 23e or	al Di	625 Murdock Rd.	21212		United States
920	be filed within 72 hours after death with the Maryland that Hygiene. ad other then "naturel", or items 23e or 28e-f show event, the Medical Exatrinational to indiffed at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 □ No If Yes, Give Year or Dates: 1954–56	 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto R Yes 2 No Specify: 	erry Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
15-0	"natur	leted	15. Decedent's Education 16a. D	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired)	g 16b.	. Kind of Business/Industry
2121	d within giene. er then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	cher/Principal		unty School System
Baltimore, Maryland 21215-0036	2 should be filed a and Mental Hygie is marked other reumatic event, It	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Henry Otto de Fries	18. Mother's Name Hilda Jo	(First, Middle, Maid hanna Gur	
Mar	s 1 and 2 should f Health and Mer item 27 is marke other treumatic			Mailing Address (Street and Number or Rural 5 Murdock Rd. Balt	Route Number, Cit imore, M	
ore,	ö O 💴 느			isposition (Name of Da crematory or other place)		Location - City or Town, State
I I	Pag nent ant: I			unt Crematory Mar. 5	, 2005 Ba	altimore, Maryland
Ba	permit. Departn Importe any inju		26ha O. Mitchell	22. Name and Address of Facility Mitchell—Wiedef 6500 York Rd.	eld Funer Baltimor	cal Home, Inc.
			23a. P. T. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCUL (Due to (or as a consequence of)			
	Examiner	<u>.</u>	Sequentially list conditions, b.			
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-		
8760,	be executed sician and burial-transit	Ical Ex	resulting in death) Last Due to (or as a consequence of)			
9	tificate ig physi as the l	Pa	d.	var.		
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the METASTATIC PROSTATE CANCER	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Vital Records,		Completed			24a. Was an autopsy performed: 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	Physicien: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp	26. Place of Death (atient 3 DOA Other: 4 Nursing Home		6 □Other (Specify)
n of		on: T	27. Manner of Death 1	ne of 28c. Injury at 28	8d. Describe how in	
Division	Il or Attending after death. Director: After	Certification;	2 Accident investigation 3 Suicide 6 Sould nick be 28e, Place of Injury - At home, farm	M 1 ☐ Yes 2 ☐ No	3f. Location (Street	and Number or Rural Route Number,
á		Certi	4 Hornicide building, etc. (Specify)		City or Town, Sta	<u></u>
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	ledical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, one	or investigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)
	To To con	Z	29b. Signature and title of certifier Proposition Process m. D	D41410	29d. [ned of Kin 2005.
	18		30. Name and address of person who completed cause of death (Item 23a) (Ty			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Recentrar's Signature	ER DRIVE TOWSON	, MARYLAI	ND 21204
	Registr	ar	MAR 0 8 2005	A STATE OF THE PARTY OF THE PAR	<u> </u>	

			State of Maryland / I State Registrar	-	artment of tificate of			iene 005	07625
	Physicia /Medic		Decedent's Name (First, Middle, Last) MARY ANN EISEL				2. Date of Deat Month MARCH	Day Year 04 2005	3. Time of Death 4:30 q. M
	Examin		4a. Facility Name (If not institution, give street and number) ST. ELIZABETH S NURSING HOME			or Location of Deal	th	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 13 − 20 − 7421 6. Sex 79	rthday) Yrs.	ff Under 1 Year Months Days			,1925 Mar	rthplace (State or Foreign ountry) yland
	aryland show	10	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Maryland N/A Balt						10d. Inside City Limits 1 XYes 2 □ No
	vith the M t or 28a-f be notified	Director	10e. Street and Number	THO	10f. Zip Code	1.000	11	0g. Citizen of What C	<u> </u>
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, it a Madical Exercited Trais be notilized at	by Funerai	11. Marital Status 1	'	Vas Decedent of	1230 Hispanic Origin? (Sban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	U.S.A. 14. Race - Am Black, Wh Specify: Wh	te, etc.
Maryland 21215-0036	Jwithin 72 hou jiene. r than "natura ir a Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Flamentary/Secondary (0.12) Coffee (1.40r.5+)	(Give life. I	dent's Usuaf Occu kind of work done DO NOT use retin	a during most of wa	rking	16b. Kind of Business	Vindustry Trust Bank
yland ;	ould ba filed Mental Hyg arked otha	To Be C	17. Father's Name (First, Middle, Last) George Eisel			18. Mother's Na Margare	me (First, Middle, M	Maiden Sumame)	
	and 2 sho aith and 127 is ma ar trauma		T					, City or Town, State. , Marylan	
altimore,	Pages 1 and of He ant: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	f Dispo	sition (Name of natory or other plants ork Cem.	ace)	Date	20c. Location - City o	Town, State
Balt	permit. Pages. Department of H Important: If Ite any Injury or of once.		21. Signature of Fune al Service Licensis	ress of Facility Olyniak F Fort Aven			yland 21230		
	Physician /Medical Examiner		23a an1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence			Approximate finterval Between Onset and Death 3 LV EUKS			
,	cata be executed physician and the burial-transit	Examiner	Sequentially list conditions, T any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence)	ŕ					
8760,		dicai	d						
O. Box 6	at the death cartific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnant	су		23d. Date of de Month	livery Day Year
rds, P	g g g	by	Part II. Other significant conditions contributing to death but not resulting	n the u	nderlying cause g	Iven in Part I.	23e. Did tob	pacco use contribute i	o the cause of death? robably 4 □Unknown
Il Records,	Tha tar ate has page 2	Completed					24a. Was ar autops perform 1 Yes 3	y prior to	utopsy findings available completion of cause of
ion of Vital	ttanding Physician: 1 daath. ctor: After this certifical y the funeral director, p	ation: To Be	1 Polatural 5 Pending (Month, Day Year) 2 Accident investigation	utpatien Time of Injury	28c. Inju	ther: 4 Mursing I		e) once 6 Other (Special Control of the control o	acity)
Division	al or Attand s after daath al Diractor: ,	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	ural Route Number,
	To the Hospital or Attanding within 24 hours after daath. To tha Funeral Diractor: After completely filled in by the fune	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.	e, death	vestigation, in my	opinion, death occ	urred at the time, da	ate and place, and du	e to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and wre of certifier	0		SZZY	6 K	9d. Date signed (Mon	th. Day, Year) 4, 2005
1)		30. Name and address of person fro completed cause of death (Item 23a) Y. P. I. R. R. G. F. R. K. T. W. K. L.	(Type,	Print)	hoice	are,	belf	WD 21228
	Sta Registi		31. Date filed (Month, Day, Vear) MAR 0 8 2005 32. Segistrar's Signature	do	asti)		,		

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			For	icuse i	State of		id / Depa							-		7626
			State Registrar				Ce	rtificat	e of L	Death		-	Reg. No	. 00		1020
	Physicia	an	1. Decedent's Name (First,						CD.	0 -	9	2. Date of De	Day		r	ime of Death
	/Medic	al	4a. Facility Name (If not inst		street and num	har)		4h City		Con Location of		Februa	1	County of De	205 /	0.05
2	Examin	er	The John	_ //.	PKINS	Hosp	41	130	4:	200	P		40.	County of De	au i	
	Funeral		5. Social Security Number	6. Se	(7	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs.	8. Date of Bir	th av Year)	9. E	lirthplace (S Country)	State or Foreign
	Director		238-74-7890	,]M 2□F		62 Yrs.	MOITINS	Days	riours	IVIII I.	8. Date of Bir (Month, Date 4 – 19 –	42	No	2	
	land		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	ty, Town or Lo	ocation							10d. ins	ide City Limits
	Mary Ind	to	MD			Ba l	timor	e							1)	Yes 2 □ No
	or 28s	lrec	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of What	Country?	
	ath wi	ral	1616 N. Bet	chel					213				US	A		
	items items	Funeral Director	11. Marital Status	Marriad	12. Was Deced	es?	.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto I	cify Yes or No Rican, etc.))-	14. Race - Ar Black, W		ian,
920	urs aft	by	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 💢 Div		1 X Yes 2 If Yes, Give Year or Da	tes:		1 ☐ Yes	X □ No	Specify:				Specify: B	lack	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinat huat be notified at	Completed	15. Dec (Specify only)	edent's Edu	cation		16a. Dece	dent's Usua	al Occupa	ation	t of workin	20	16b. K	ind of Busine:		
21	within ene. than "	mple	Elementary/Secondary (0		College (1-	4or 5+)		kind of wo DO NOT us)	CO WOIKI	19				
	filed w Hygier othar ti		12th 17. Father's Name (First, M.	iddle Last)			Cab	Driv	er	18 Mothe	ar's Namo	(First, Middle	Ta			
an	ld be ental ked o	To Be	Frank Litt									ta Eb		ournamo)		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Itam 27 is marked othar than "natural", or items 23a or 28a-f show or other traumatic event. It a Medical Examiner must be multiply at	-	19a. Informant's Name/Rei		rpe, Print)		19b. Maili	ng Address	(Street a			l Route Numb		r Town, State	, Zip Code,	
	and 2 ealth a n 27 is		Andrey Cru	nitie						nel		Balto				
ore	ges 1 t of Hi If Itan or oth		20a. Method of Disposition 1X Burial 2 ☐ Crema	ution 3 □F	Removal from S		Place of Dispo cemetery, cre	osition (Nar matory or o	ne of ther plac	9)	D	ate	20c. Lo	ocation - City	or Town, St	ate
Baltimore,	it. Pa rtmen rtant: njury		* 4 □ Donation 5 □ Oth 21. Signature of Funeral Se			Ga	rrisc	n Fo	rest	t :	3-10	-05	Owi	ngs M:	ills,	MD
Ва	permit. Pages Department of I Important: If Its any injury or of		All India	ess Licens	0/10	f.	2	2. Name an	Fact	s of Facilit	Wes	ley C Balt	hav:	is Jr	FH	
	•		23a. Part1. Enter the disea shock, or heart failure	or comp	ications that ca	used the deal								10 212	Appro	ximate
	Physician :		Immediate Cause (Final disease or condition	List only o											Onse	al Between t and Death
	/Medical		resulting in death)	-	Due to (c	diopu or as a consec Ver	quence of):	x 5)	7 % 2	eat					-	NAN-
r	Examiner	_	Sequentially list conditions,	- 1	deex	ver	rous	Thro.	ناطه	خاذ					2	weeks
	ted nsit	nine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	~	C A		uence on:									weeks
Ć.	te be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last		:. <u> </u>	r as a consec	uence of):								7000	w.,2
68760,		Ical			d											
	entifica ling ph e as th	Med	IF FEMALE:	182				ate -								
Box	death certifica e attending ph d for use as th	Physician/Med	23b. Was decedent pregna in the past 12 months'	(B)		ome of pregn: th 2□Feta int at time of c	al death 3	□Ectopic pr						23d. Date of o Month	delivery Day	Year
o.		nyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkno		jeatii 5t	Other (sp	өспу)							
S, P	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant co	nditions co	ntributing to dea	ath but not res	sulting in the u	ınderlying c	ause give	n in Part I		23e. Did	tobacco u	use contribute	to the cau	se of death?
rds	w require been sig should b		High Bl	ood	pressu	re						1 🗆	Yes 2	□No 3□	Probably	4 Dunknown
Record	elawr hasbe je 2sh	ompleted	Lung Car	cer								24a. Was	DSV			dings available in of cause of
E B	Th ate pag	Con	Adrend	- 1	icien	ch						perfo	2XI No	death 1 🗆 Y	? es 2□N	0
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to m examiner?	-	Hospital:	· · · · · · · · · · · · · · · · · · ·	(500 : ::		Othe	ar.		(Check only				
of	ding Physib. After this funeral di	Η.	1 Nes 2 No 27. Man r of Death		28a. Date of	Injury	EP/Outpatie 28b. Time o		8c. Injury	at at		ne 5 🗌 Resi 28d. Describe			oecify)	
ion	Attending r death. actor: After by the fune	atlo	2 Accident	ending vestigation	(Montr	, Day Year)	Injury	М	Work	? Yes 2 🗀	No					
Division	i or Attendafter death Diractor:	ertification;		ould not be letermined	28e. Place o	of Injury - At h g, etc. (Speci	ome, farm, st fy)	reet, factory	, office		4	28f. Location (City or To			Rural Rout	Number,
	pital o	O	29a. Certifier	difuine Dhu	ololon, T. d.				-4 N 4'							_ITTERSEEN_
	24 hos B Fun etely	edical	(Check only 2 Me	dical Exam	sician: To the i ner: On the ba and mann	sis of examina	ation and/or in	n occurred vestigation	at the tim , in my or	ie, date an pinion, dea	th occurre	and due to the	date and	and manner d place, and o	as stated. lue to the ca	luse(s)
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in E	Me	29b. Signature and title of o	ertifier						number				te signed (Mo		
	-		10)	MEDI	in Dox	JOVE		_]	DO	061	84	3 ve ë, 1	MAK	eh 3	3,20	205
2)		30. Name and address of p				m 23a) (Type,	Print)	1	70	11.		11.	1. /	2 12	vy
			SANJAY I	Year)	400 32 Ba	gistrar's Signa	ature		ct	DA	Him	oce, /	risky	Wind	212	6 /
	Sta Registr				la >	gistial's signi	free	W					•			
		204	MAR 0-8	2005	AL SEL	J. W.	1									

ORIGINAL

		1	For State Registrar AMEND TTEM	State of Ma								jiene	05	07627
			Decedent's Name (First, Middle, Last,	#) PER F	nG04	H 3/ L.	,,,,,,][[2	2. Date of Dea Month		Year	3. Time of Death
	/sicia		Violet Virgin	ia Elling	er					N	March	6	2005	11:37 A ^M
	ledic: amine	_	4a. Facility Name (If not institution, give				4b. City, 1	Fown, or	Location o	of Death		4c. Coun	ty of Death	
	•		8350 Peachwood Dr	ive				Je	ssup				Howar	d
Fund	eral	:	5. Social Security Number 6. Sec	x 7. Ag	je (In yrs. l	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8	B. Date of Birth (Month, Day	Year)	9. Birth	olece (State or Foreign
Direc		İ	212-26-1 452]M 2⊠F	75	Yrs.	Wichting	Days	110010			, ĺ929		gínia
ъ.		-	Usual Residence of Decedent		10- 01-	. Town or Lo								10d. Inside City Limits
arylar	100		10a. State 10b. County		Toc. City	, TOWIT OF LC	Cation							1 ☐ Yes 2 No
Ba-f	=	5	MD Howard			Jessu					1			
or 2	5	Director	10e. Street and Number				10f. Zip		704			10g. Citizen o		ntry?
death with the Maryland	180	ra	8350 Peachwood Dr						794			14.5	USA	and ladies
ar de tems	Date	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	S. 13.	Was Deced If Yes, spec	ent of His	n, Mexicar	n, Puerto R	ify Yes or No- ican, etc.)	14. B	ace - Ameri lack, White,	
s afte	and and	by F	1 ☐ Never Married 2 ☐ Married 3√3√Widowed 4 ☐ Divorced	1 ☐ Yes 2XX If Yes, Give Year or Dates:	Q 10		1 ☐ Yes 2	XXNo	Specify:			Spec	oify: Whi	te
∠ I ∠ I ⊃-UU30 Illed within 72 hours after death with the Marylan Hygiene. Hygiene. June than "naturel", or Items 23a or 28a-f show ther than "naturel", or Items 23a or 28a-f show Marylan Than "naturel". June 1 June	al Ex		15. Decedent's Edu			16a. Dece	dent's Usua	I Occupa	ition			16b, Kind of		
0 72 au	opa	Completed	(Specify only highest grad	le completed)	-)	(Give	kind of wor DO NOT us	k done d	lurina mos	st of working	7			,
ZIZ Ziene. giene. ar than	Ta N	mo	Elementary/Secondary (0-12) 6th	College (1-4or	5+)	Hom	emake	r				C	wn Ho	me
<u> </u>	+	Ö	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle,	Maiden Sum	ame)	
id be ental	No o	To Be	Leonard P. Cu	rtis					Ann	ie Mae	e Forbe	es		
Maryiand d 2 should be file th and Mental Hy ? is marked oth	ımat	_	19a. Informant's Name/Relationship (T)	(pe, Print)		19b. Mailie	ng Address	(Street a	nd Numb	er or Rural	Route Numbe	r, City or Tow	m, State, Zij	o Code)
MG 2 Prod	r treu		Marie I. Miles/S	Sister		6520	Pape	r Pl	ace,	High.	land, N	1D 2077	77	
Ore, Maryland es 1 and 2 should be fi of Health and Mental H if item 27 is marked ot	othe	Ī	20a. Method of Disposition			lace of Dispo	osition (Nam	ne of ther place	9)	Da	te	20c. Location	n - City or T	own, State
Pages Pages nent of ant: If its	y or		1 XBurial 2 ☐ Cremation 3 ☐ 8 4 ☐ Donation 5 ☐ Other (Specify,)	vage C			1	3/9/	2005	Savage	e, MD	
Baltimore, permit. Pages 1 a Department of Hec Importent: If item	inju		21. Signature of Funeral Service Ligens			_			s of Facili	ty Don	aldson	Funera	al Hom	ne, P.A.
B S S	any		& Law When		M0016	0	313 T	albo	tt A	venue	, Laure	el, MD	2070	17
			23a. Pan Enter the disease, or comp	lications that cause	d the death	n. Do not en	ter the mod	e of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
Physic	nian		shock, or heart failure. List only of Immediate Cause (Final			l Thro	mhosi	S						Onset and Death Minutes
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Ļ		je.	Sequentially list conditions, if any, leading to immediate	Due to (or as	s a conseq	uence of):								
) pet p	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
0, , exect an an an	rial-tr		resulting in death) Last	Due to (or as	s a conseq	uence of):								
I Records, P.O. Box 68760, < The law requires that the death certificate be executed ate has been signed by the attending physician and	the burial-transit	Physician/Medical	(d										
68 tifica tig ph	as th	Med	IS ESTABLE.											
OX th cer	for use as t	an/N	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			⊒Ectopic pr	egnancy					Date of delivery	ery Day Year
G deatl	od be	sicia	in the past 12 months? 1 Yes 2 No	4□Pregnant a 9□ Unknown			Other (sp	ecify)				, i	VIOLET	bay roar
P.O. at the 1by th	stached	h	9 Unknown								22 Did to		atributa ta	the cause of death?
S, les th	be del	by	Part II. Other significant conditions co		ser fon Jud	uiting in the u	inderlying c	ause give	en in Part	1.		res 2 □ No		vv
cord v require been si	73	ted	Carcinollace	7515										
Records, he law requires to has been signed	CV	Completed									24a. Was autop	an 24t	b. Were aut	opsy findings available ompletion of cause of
The Help	page	Corr									1 Yes	rmed? 2XXIIo	death?	2 🔀 No
Vital Fiction: The certificate	al director, page	Be (25. Was case referred to medical examiner?					1		e of Death	(Check only o	ne)		
of V Physic this ce	l dire	70	1 ☐ Yes 2√∑ No			ER/Outpatie			4 🗆 14		e 5 XResid			fy)
Vision of Vital Attending Physicien: r death.			27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of In (Month, D	jury ay Year)	28b. Time o Injury		8c. Injury Worl	xat k?		8d. Describe h	now injury occ	urred	
Division of Vital or Attending Physiclen: after death. Director: After this certifica	by the funer	ertification:	2 Accident investigation				М		Yes 2□		m() ' (
or Att	n by I	ıţ	3 Suicide 6 Could not be 4 Homicide determined	289. Place of II	njury - At he etc. (<i>Specil</i>		treet, factory	, office		2	City or Tox		mber or Hui	al Route Number,
Division To the Hospital or Attend within 24 hours after death	completely filled in	O	v											
the Hospital hin 24 hours a	ely fi	edical	(Check only 2 Medical Exam	ysician: To the bes iner: On the basis	of examina	owledge, dea ation and/or i	th occurred nvestigation	at the tin	ne, date a pinion, de	nd place, a ath occurre	nd due to the d at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
the l	nplet	Med	one)	and manner s	stated.		290	Licens	e number			29d. Date sig	ned (Month	Day, Year)
T with	00	-	29b. Signature and Ale of confiner	4 11/2	nu	MIN	250	1	170	7/1		March		
Ŧ			10000	. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				الا	17	110		LIGI CII	, , 200	
	10		30. Name and address of person who william A. W			п 23a) (Туре 321 Pr	ince (Georg	ge St	reet,	Laure	l, MD	20707	
	V		31. Date filed (Month, Day, Year)		trar's Signa					•				
R	Sta egist		MAR 0 8 20	_	_	KA	back !	,						

DHMH 17 Rev 1/2001

ORIGINAL

		rieas	e Type of Fillicia				-	•	
		For	State of Maryla				Mental Hyg	iene 2005	07628
		1 - State Registrar		Cert	ificate of	Death	R	eg. No.	01020
		1. Decedent's Name (First, Middle,	Last)				2. Date of Deal	h Day Year	3. Time of Death
	Physician /Medical	Wilbur	M	Elv	vell		March	7 619, 200	5 8:15A M
S. S.	Examiner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death	1	4c. County of Deat	10 101
		Morts Br	undal Ho	(which so	6	in IS	Fram	Anne	13 most
	Funeral	5. Social Security Number 6	Sex 7. Age (In yrs	s. las birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt	nplace (State or Foreign untry)
- 10	Director	577-09-6303	1M 2□F 87	Yrs.	Months Days	Hours Min.		7.1917 Wasi	ninaton D.C.
	g	Usual Residence of Decedent						, , , , , , , , , , , , , , , , , , , ,	
	how	10a. State 10b. County	10c. C	City, Town or Loca	ation				10d. Inside City Limits
	a-f a	Maryland Anne A	rundel Pa	sadena					1 ☐ Yes 2 ☒ No
	be filed within 72 hours after death with the Maryland tall Hygiene. ed other than "natural", or tiems 23a or 28a-f show event, the Medical Examinar must be notified at Be Completed by Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	23a 23a	1585 Marco Dr.			211	22		USA	
	r items 236	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. W	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
9	after or fte		d 1 X Yes 2 No				o rican, etc.)	Black, White	
සු	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	"	☐ Yes 2 🕅 No	Specify:		Specify:	white
9	72 hg	15. Decedent's (Specify only highest		16a. Decede	ent's Usual Occup	ation during most of work	king	16b. Kind of Business/	ndustry
215	Pun Pun Pun Pun Pun Pun Pun Pun Pun Pun	Elementary/Secondary (0-12)	College (1-4or 5+)	life. De	O NOT use retired	d)	\"'''		
21	e filed within 72 hours a la Hygiene. I other than "natural", ovent, the Modell Example, and Completed by	12		US	Navy F	light En	gineer	U.S. Gov.	·
g		17. Father's Name (First, Middle, La				18. Mother's Nam	ne (First, Middle, I	Maiden Surname)	
<u>a</u>	Mentice attice	Marshall	El we	11		Kather	ine	Buo	ckley
a Z	2 should be and Mental is marked of sumatic even	19a. Informant's Name/Relationshi	(Type, Print)	19b. Mailing	Address (Street	and Number or Ru	ral Route Number	City or Town, State, Z	ip Code)
Σ	2 4 5 E	Ruth Rilee	daughter	1585	March D	r. Pasad	ona MD 2	1122	
5	of Healitem	20a. Method of Disposition	20b.	Place of Disposi	ition (Name of atory or other place		Date	20c. Location - City or	Town, State
e E	Peges nent of I int: If its iry or o	1 XBurial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State	* *	irfax Ce	· 1	/9/05	Fairfax Vi	rainia
Baltimore, Maryland 21215-0036		21. Signature of Funeral Service Li			Name and Addres		777.77		
ã	permit. Departr Importa any inje	I du d. X	/ /			2	tallings	Funeral Ho	ome P.A.
	* B-8-8	23a. Part1. Enter the disease, or a shock, or heart vilure. List of	mulications hat caused the dea					a MD 21122	Approximate Interval Between
		shock, or heart vilure. List of Immediate Cause (Final	ty one cause on each line.	000	200 10-0	26			Interval Between Onset and Death
	Physician /Medical	disease or condition resulting in death)	a	Pywv	70000	177			
	Examiner		Due to (or as a conse	equenca or):	nd a	100 87	c 8	makon	0
		Sequentially list conditions,	b. Due to (or as a conse	mence ot).	CA JA	101011		July All	~
	executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	U	3.7.	' /			0	
	xecu and II-trai	that initiated events resulting in death) Last	c Due to (or as a conse	aquence of):					
760	8 8 9								
687	w 2 0 0		d						
3 8	ding se as	IF FEMALE:	23c. If yes, outcome of pregr	nancy					
S 18	atten for u	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet	tal death 3 DE	Ectopic pregnancy			23d. Date of deli Month	very Day Year
- b	the s	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	death 5	Other (specify)				
11 6	es that the death certifical gned by the attending phy be detached for use as the Drysiclan/MedI	Part II. Other significant condition	S contributing to death but not re	eulting in the unc	darhvina causa ave	en in Part I	23a Did tol	pacco use contribute to	the cause of death?
is,			o contributing to doubt but not re	ssaking in the and	zarry ing cause giv	on in anti.	1 🗆 Ye	,	bably 4 Unknown
Record	: The law requir							is 2140 31110	
Sec 2	The law te has boage 2 sl						24a. Was a autops	y prior to d	topsy findings available ompletion of cause of
	The la						perform	ned? death?	2500
Vital	Physicien: The rathis certificate ral director, pag					26. Place of Dea	th (Check only on	θ)	
	% ∞ ₽ O		Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA Oth	er: 4 🗆 Nursing H	ome 5 🗆 Reside	nce 6 Other (Spec	ufy)
	ng Pl		28a. Da e of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	y at k?	28d. Describe ho	w injury occurred	
<u>.</u> <u>.</u> <u>.</u>	tending death. stor: After the fune	2 Accident investiga	tion	''		Yes 2 □No			
ر Division	or Attend after death Director: , I in by the t	3 Suicide 6 Could no 4 Homicide determin		home, farm, stree	et, factory, office		28f. Location (St. City or Town	reet and Number or Ru	ral Route Number,
0 0	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Medical Certification:							,,	
Kr.	Hospital 24 hours a Funerel (letely filled		Physician: To the best of my kn	nowledge, death	occurred at the tin	ne, date and place,	and due to the ca	use(s) and manner as	stated.
,0 x1	the Hosp nin 24 hou the Fune apletely fil		and manner stated.	iation and/or mye	stigation, in my o	pinion, death occur	rred at the time, of	ate and place, and que	to the cause(s)
	within 2 To the complet	29b. Signature and little of certifier	$\leq mn$		29c. License	e number	2	9d. Date signed (Month	Day, Year)
		X	= 1 ""	1	DH8	3000	10	3/07	2005
		30. Name and address of person w	ho completed cause of death (Ite	em 23a) (Type, P	rint)	x () x		1 0	2005
		KUF 150	MTEY,	501	Hrospo-	ton)	Vr/ 6	ا سرا ²	The Line
	State		32-Registrar's Sign	nature	W -		/		
	Registrar	MAR 0.8.2	005 Jane 1	U. Agos	We!				

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	-	artment of H rtificate of L			ene g. No.2 0 0 5	07629
	Physici		1. Decedent's Name (First, Middle, La	st)		FOR	USV :	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, given The Johns Ho	PKINS Hospita	/	4b. City, Town, or	Location of Death	CUZUNU	4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 204.54.3640	M 2□ F 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUNE 30	1942 PEN	place (State or Foreign Intry) INSYLYANIA
	ith the Maryland or 28a-1 show	tor	10a. State 10b. County	, ,	yown or Lo	timore				10d. Inside City Limits 1 ■ Yes 2 ■ No
	h with the	ai Director	10e. Street and Number 1323 L/M11	AYE.		10f. Zip Code	21239	10	g. Citizen of What Co.	untry?
5-0036	72 hours after death with the Maryland 'natural', or Items 23s or 28s-1 show dical Examinar must be incitified at	by Funeral	11. Maritar Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent of Hi f Yes, specify Cubal 1 Yes 2 Mo	spanic Origin? (Spenn, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
1215-0	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	furing most of workin	a	6b. Kind of Business/I	DECURITY
land 2	2 should be filed and Mental Hygis Is marked other sumatic event, I	To Be Co	17. Father's Name (First, Middle, Last,	ENEY			18. Mother's Name			
Baltimore, Mary	. Pages 1 and 2 sh tment of Health and tant: If Item 27 Is m jury or other traum		1) Informant's Name/Relationship (ORK STEP) 20a. Met/lod of Disposition 1 V Burial 2 Cremation 3 Communication 5 Other (Specification) 21. Signature of Funeral Service Licer	HAN MOTHER 20b. Placen Placen 30 Pla	LO L ce of Disponetery, crem	AVENUE sition (Name of natory or other place for EST	ESTATE	S APT	City or Town, State, Z III CHESTE DC. Location - City or T CHILLS CKEENE F	C. PA 19013 Town, State S. MARYLAND
ä	Deprini		23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused the death.	Do not ent	905 York er the mode of dying	K ROAD	BATIN	DORE, MAR	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		Onset and Death					
8760,	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Adult RESP Due to (or as a consequence. Due to or as a consequence.	LATOR	Sepsis	ess Sym	dromê	5	8 Days 10 Days
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
s, P	uires that i signed by Id be deta	by	Part II. Other significant conditions of the Ty Infection		ng in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Record	The law require tate has been signage 2 should b	Completed	Acute Renal	Failuré				24a. Was an autopsy performe	prior to d	opsy findings available ompletion of cause of
f Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpatient 2 EF	VOutpatien	t 3 DOA Othe	26. Place of Death	(Check only one,		fy)
Division of	ttending Ph death. ctor: After th y the funeral	Certification; 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work M 1 🗆 Y	at 2 ? Yes 2□No	8d. Describe how	injury occurred	
Divi	ital or Attend irs after death ral Director; /	Certif	4 Homicide determined	building, etc. (Specify)			1	City or Town,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	Tot Tot	M	29b. Signature and title of certifier Peur Pe	nGapto			5-000		3/2/05	•
F)		30. Name and address of person who DEVI SENGUIPTH	completed cause of death (Item 2	3a) (Type.	Print) Bal	FIMORE. 1	MARYLA	Nd 2128	7
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 8 200	2. Registrar's Signatur	e diag	W	1	7.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Nile Fish August Jr. 03 10:35 P^M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 999 Hilltop Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 7 (Month | Days Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 66 217-34-3816 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be politied at MDAnne Arundel Glen Burnie 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 999 Hilltop Road 21060 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Experience ODEs. Amed Forces? 1 X Yes 2 □ Black, White, etc. 2 No 1955-1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates: þ 1959 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Industry Iron Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nile August Fish Bessie Norton Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 999 Hilltop Rd., Glen Burnie, MD 21060 Mrs. Kathy Fish / wife 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 5-05 Stevensville, MD ` 4 ☐ Donation, 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signaty 1 Second Ave SW, Glen Burnie, MD 21061 molley 2/ a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im rediate Cause (Final sepatoma Pnysician direase or condition resulting in death) /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (2183888 or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 DEctopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has al director, page 2 autopsy performed 21 No 1 ☐ Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 steel esidence 6 Other (Specify) 1 Tes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 Tyes 2 No investigation 2 Accident naral Diractor: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral I t Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 (30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

harles J. Wu MD

MAR 0 8 2005

31. Date filed (Month, Day, Year)

2. Registrar's Signature

1600 5. Crain Hung Ste. 106, Gren Burnie, MD 21061

			1 - For State Registrar	State of	Maryla				lealth a Death	ind M	ental Hy	ygien Reg. N	-2111	05	0763
П	Physic	an	Decedent's Name (First, Middle,	•				•			2. Date of D Month		ay	V	3. Time of Death
	/Medi	cal				L. Fisk							5, 2005	Year	950pm M
	Exami	ner	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	Death		4	c. County o	f Death	
	Funeral	•		erick Villa Nur		nter . last birthday)	If Unde	r 1 Year	If Under 2		nsville	i de		Baltin	
	Director		053.20.0899	1□M 20F		93 Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D	ay, Yea	r)	9. Birthpla Country	ce (State or Foreign y)
	p .		Usual Residence of Decedent								April 27	7, 191	1	Ne	ew York
	be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene ad other than "neturel", or items 23a or 28e-f show event, I's Medical Evanical nurst be notified at	Director	Maryland 10e. Street and Number	Howard	10c. C	ity, Town or Lo			licott City	y				100	d. Inside City Limits 1 ☐ Yes 2 No
	with a or						10f. Zip	Code				10g. C	itizen of Wh	at Country	y?
	death	Funeral	10365 Tuscany Drive	12 Was Decede	ent Ever in I	18 13	Man Dane	dant -6 ():	2104	-				U.S.A	
21215-0036	urs after o	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date		5.3.	vvas Dece If Yes, spe 1 ☐ Yes	V	spanic Origin, Mexican, Specify:	Puerto F	cify Yes or Ni lican, etc.)	0-	14. Race Black, Specify:	White, et	n Indian, c. /hite
5-0	72 ho netur	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usu	al Occupa	ition			16b. I	Kind of Busi		
21	within iene.	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	(GIVe	kind of wo DO NOT u	nk done d	lurina most i	of workin	g				•
2	filed w Hygier Ither th		12			<u> </u>		boo	kkeeper				_	financ	e
ano		Be	17. Father's Name (First, Middle, La	st)					18. Mother	's Name	(First, Middle	, Maide	n Sumame)		
Maryland	should by	은		Vanderwark							Eu	nice	Bradwa	y	
Ma	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship	(Type, Pnnt)							Route Numb			ate, Zip C	ode)
	1 all Hea Hea Hea Hea the		Mr. Francis Fisk 20a. Method of Disposition	S	20b.	Place of Dispo	sition /Nar	ne of	1	Ellicott Da	City, Ma			T.	2
JUO TI	Pages nent of int: If it		1 Burial 2 Cremation 3	Removal from Sta	ate	cemetery, crer	natory or o	ther place	9)	5/	2	20¢. L	_ocation - Ci	ty or lowr	n, State
Baltimore,	- Fair		21. Signatura of Funeral Service Lic		MANIZ	293 Wes	Hill Ce	emeter	s of Facility	5 · 8 ·	05		Pain	ted Pos	st, NY
ä	permi Depa impo any ii		Mulphidac	Work ich	17		9	lack E	uporal H	lome	РΔ				
			23a. Part1. Emer the disease, or co shock, or heart failute. List on	mplications that care	sed the dea	th. Do not ent	er the mod	871 Ol	d Colum	ibia Pi	ke Ellicol	tt City	, MD 21	043 A	pproximate
	Physician		Immediate Cause (Final disease or condition			onary i								0	pproximate Iterval Between Inset and Death
	/Medical		resulting in death)		as a consec		arres	L					_	Fev	V Hours.
Н	Examiner		Sequentially list conditions	Corona	ary Ar	tery D	iseas	e						Vor	·ra
	p ti	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions)	Due to (or	as a consec	quence of):								160	ars.
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	·	Hypertension Due to (or as a consequence of):							Yea	ars.		
8760,	be ex	E		Due to (or	as a consec	quence of):									
	phys phys the	dlcal	•	d										-	
9 x c	eath certific attending p	//Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of prean	ancv									
Вох	death a atter	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	ıl death 3 □	Ectopic pro						23d. Date of Month	-	y Year
P.O.	that the de ed by the a detached f	hys	1 Yes 2 No 9 Unknown	9□ Unknowr											
Records, F	The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	Part II. Other significant conditions Senile Dementi	contributing to death	but not res	ulting in the un	derlying ca	ause givei	n in Part I.		1	obacco Yes 2			ause of death?
000	s been si	olete	Degenerative (steo-arth	ritis					_	24a. Was				
Re	ysicien: The lav is certificate has director, page 2	шо								_	autop	sy rmed?	prio dea	r to compli	findings available etion of cause of
Vital	iclen: Th certificate ector, pag	0	25. Was case referred to medical						00 Di4	(D	1 Yes		1 🗆	Yes 20	₹No
	ysici is cer direc	To B	examiner? 1 ☐ Yes 2X No	Hospital:	atient 2	ER/Outpatient	3 DO	Othor			Check only o		2 001		
0	ding Phy h. After thii funeral c		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Ir		28b. Time of Injury		Bc. Injury : Work?			d. Describe t			<i>Эреспу)</i>	
0	uttendii death. ctor: A y the fu	atle	2 ☐ Accident investigate	on	-uy . ou.,	injury	М		es 2□No						
Division of	itel or Att rs after d el Direct led in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								Location (S City or Tow	Street an vn, State	nd Number o	or Rural Ro	oute Number,
	to the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier	hysician: To the be miner: On the basis and manner	UI BAAIIIIIIa	wledge, death tion and/or inv	occurred a estigation,	it the time in my opi	, date and p nion, death	occurred	due to the dat the time, d	cause(s) date and	and manne place, and	r as stated due to the	d. cause(s)
	To With	2	29b. Signature and title of certifier	0 11.				License				29d. Dat	te signed (M	fonth, Day	, Year)
	1.		V. B. Vel	le do			-	304	69.		1	Marc	h, 7,	200)5.
	10		30. Name and address of person who N B Vellanki, MD;	9055 Ch	evrol	et Driv	Print) 7e, #	100,	Ellic	ott	City,	MD 2	21042.		
•	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 200	2. Regis	strar's Signa	ture Span	W								

DHMH 17 Rev 1/2001

)		٠,	1- For Unpend Item 23a,27,28a-i perme 6842 4-8-05 tas Registrar Amend Item 23a per me 6844 Certificate of Death 6-9-	Mental Hyg -05 tas i	giene 005	07632
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	/Medic	al	Harold Lee Giddings 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	March		1220P. M
	Examin	er	4a. Facility Name (If not institution, give street and number) University Hospital 4b. City, Town, or Location of Death Baltimore	1	4c. County of Deat	1
754	Funeral Director		5. Social Security Number 220-66-6094 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 48 Yrs. 1 Months Days Hours Min.	8. Date of Birt (Month, Da) Aug. 29	h 9. Birti	nplace (State or Foreign untry) many
1	land ow if		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	death with the Maryland ime 23s or 28s-f show Fittust be notified at	tor	Maryland Anne Arundel Glen Burnie			1 ☐ Yes 2 🔀 No
	ith the	Direc	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	ath w	rai	910 Langley Road 21060		United Sta	
980	be filed within 72 hours after death with the Maryla ital Hygiene. Id other then "natural", or itame 23e or 28e-f ehov event, Ite Medical Examination to indiffed at	l by Funerai Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert In Large 2 □ No If Yes, Give Year or Dates:	pecify Yes or No- o Rican, etc.)		
Maryland 21215-0036	be filed within 72 hours after lat Hygiene. d other than "natural", or Ita evant, I'z Medical Examina	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking	16b. Kind of Business/	•
7	filed wit Hygiene other tha	CO	11 Stocker 17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle,	Retail S Maiden Sumame)	ales
au	2 should be filed within and Mental Hygiene. is marked other than sumatic evant, Its M	To Be		ıd Walter	•	
ary	shou and M s mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ıral Route Numbe	r, City or Town, State, Z	ip Code)
	and 2 ealth in 27 in 27 in an tre				incinnati,	
Baltimore,	permit. Pages I and 2 should be Department of Health and Menta important: if itam 27 is marked any injury or other traumatic evence.		20a. Method of Disposition 1)5	20c. Location - City or Catonsville	e, MD
Ball	permit Depart impor any in		21. Signa from Fig. ral Service Licensee. 22, Name and Address of Facility Kirkley-Ruddick Fu 421 Crain Highway			21061 Maryland
	Pnysician /Medical Examiner	-	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	complic	ations	Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to infractal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Oue to (or as a dons equence of): c. Due to (or as a consequence of): d.			
Box	Attanding Physician: The law requires that the death cartif r death. ector: After this certificate has baen signad by the attending by the funeral director, page 2 should be detached for usa as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Unknown Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) O		23d. Date of deli Month	v ery Day Year
rds, P	w requires that baen signad b should be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to res 2 □ No 3 □ Pro	
Vital Records, P.O.	sician: The law re certificate has ba rector, page 2 sho	Completed		24a. Was a autop perfor Yes	sy prior to o death?	opsy findings available ompletion of cause of
Vita	sician: Th certificate rector, pag	Be	examiner?	ith (Check only o		
Positian: 1 Manner of Death 1 Manner of Death 1 Manner of Death 1 Manner of Death 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other 28b. Time of 28c. Injury at 28d. Describe how injury occurre						
ion	ttanding P death. stor: After i	atior	27. Manner of Death 1		Assaulted	
Division of	in the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f Location (S	treet and Number or Run, State) 4600 Ca	ral Route Number, Irtis Ave.,
	he Hospital in 24 hours a he Funaral (pletely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion and death occurred at the time, date and da	, and due to the c rred at the time, c	ause(s) and manner as date and place, and due	to the cause(s)
	To the l within 2 To the l complet		29b. Signature and title of certifier Calmillar Al- 29c. License number OCME	M	29d. Date signed (Month larch 02, 20	
_	gold		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street	Baltir	more, Maryla	and 21201
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 2005 32. Registrar's Signature			

Joseph Giordano 05-01596 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend tem#9, per#H, C841, 3/9/05TI

		•	- State Amend Item 1	&Unpend I	tem 23a	rii fi 8 at e ^E o Pi	really and 1	1 3-14-0	5 tas 05	07633		
	Physici		1. Decedent's Name (First, Middle, La JOSEPH L.	st) EO GIORDAI	NO JR.			2. Date of Deal Month March	Day Year 03 2005	3. Time of Death 7:45 A M		
	/Medid Examin		4a. Facility Name (If not institution, giv				Location of Death		4c. County of Dea			
			2059 Griffis Ave		//m In add indicate	Baltin	NOTE If Under 24 Hrs.	Day of Birth	N/A	**		
	Funeral Director			M 2□ F	(In yrs. last birthday) 24 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day) Sept. 1	5,1980	thplace (State or Foreign buntry) 24 MD		
)	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	e-f sh	ctor	Maryland N/A		Baltim	ore				1/1 Yes 2 □ No		
	with the	Director	10e. Street and Number 2059 Griffis A	venue		10f. Zip Code	21230	1	1.5	J. Citizen of What Country?		
	death	Funeral	11. Marital Status	12 Was Decedent F	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race - Ame Black, Whi	erican Indian,		
Maryland 21215-0036	d within 72 hours after death with the Maryland liene. I then "neturel", or Items 23a or 28e-1 show The Medical Evanther must be inclifted at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:	o moan, etc./	Specify: Wh			
5-0	netur	etec	15. Decedent's E (Specify only highest gra		16a. Dece (Give	dent's Usual Occup	ation during most of wor	king	16b. Kind of Business	/Industry		
121	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired Disabled	o)		None			
קפר	Hyg Hyg Sthe	Be C	17. Father's Name (First, Middle, Last				18. Mother's Nar	ne (First, Middle, I	Maiden Sumame)			
ylar	should be and Mental marked o	ToE	Joseph Leo (Belin		Hayes			
Mar	12 ha		19a. Informant's Name/Relationship (Tabitha VanKirk (r. City or Town, State, . ore, Maryl.			
ē,	1 an Heal em 2 ther		20a. Method of Disposition	-	20b. Place of Dispo cemetery, cre			-	20c. Location - City or			
imo	0 0		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State (y)	l	Crematory	1 .	7-05	Baltimore,	Maryland		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatul of Funeral tervice Lice). Wayne Ost	terling 2	2. Name and Address Cully-Po 37 East P	ss of Facility lyniak F atapsco		ome P.A.	21225 Maryland		
			23a Part1. Enter the disease, or com	plications that caused	the death. Do not en					Approximate Interval Between		
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Methador	ne And Pher	ncyclidin	e intoxi	cation		Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
	*	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):							
	scuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Closeas or Ir ju.) that initiated events resulting in death) Last	с								
68760,	ifficate be executed g physician and as the burial-transit		resulting in death, East	Due to (or as	a consequence of):							
	i on α	ledical		_ d								
Box	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1☐Live birth 4☐ Pregnant at 9☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year		
P.0	at the de	Phys	9 Unknown		ut not requising in the		an in Don't	220 Did tol	hacco uso contributo t	a the cause of death?		
	n requires that been signed I should be det	by	Part II. Other significant conditions	contributing to death bi	ut not resulting in the L	anderlying cause giv	en in Part I.		bacco use <i>co</i> ntribute t es 2 ☐ No 3 ☐ P	robably 4 Munknown		
Records,	The law recate has been page 2 sho	Completed						24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of		
Vital		0	25. Was case referred to medical				26. Place of Dea	1 XYes		s 2□No		
of V	hysici this cer al direc	To B	examiner? 1X∑Yes 2 ☐ No	Hospital: 1 ☐ Inpatie			er: 4 🗆 Nursing H	lome 5 Reside		city) at scene		
o uo	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Found Found	Found	Wor	yat k? Yes 2. ∰TNO	28d. Describe ho	ow injury occurred	ınk		
Division	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	3-3-200	ury - At home, farm, st	A	Λ	28f. Location (SI City or Town		ural Route Number, CIFFIS Ave.		
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C		nysician: To the best of miner: On the basis of and manner sta	examination and/or in			, and due to the c	ause(s) and manner a			
	To the Hos within 24 ha To the Fun completely	Me	29b. Signature and title of certifier	and mamor do		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)		
	-		> anete			00	CME		March 03	, 2005		
	(5)	30. Name and address of person who		0		mm Chin	L D 1		1 01001		
	Sta	ate	31. Date filed (Month, Day, Year)	- 49	M P ar's Signature	4	enn Stree	t Balti	more, Mary	Land 21201		
	Regist			2005	wes H. l.	marke						

			State of Maryland / Department of State of Maryland / Department			iene 2005	07634			
			Decedent's Name (First, Middle, Last)		2. Date of Deat		3. Time of Death			
	Physicia		MICHAEL E. GALUSKA J	r •	March	02, 2005	3:40 a M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
			873 South Shore Road	Pasadena		Anne Aru	ındel			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Birthi	place (State or Foreign			
ш	Director		218-28-7558 / /1 // // // // // // // // // // // /		Jan. 25	, 1933 Ne	W York			
	and W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			Od. Inside City Limits			
	Aaryli f sho	ō	Maryland Anne Arundel Pas	adena			1 ☐ Yes 2 🗷 No			
	28e-	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	ntry?			
	3e or		873 South Shore Road	21122		U.S.A.				
	death ms 2;	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ameri				
36	d within 72 hours after death with the Maryland piene. It then "neturel", or Items 23e or 28e-f show the Madical Examilment and the mutified at	by Fur	1 □ Never Married 2 1 Married 1 1 1 Yes 2 □ No	f Yes, specify Cuban, Mexican, Puerti I □ Yes 2tt No <i>Specify</i> :	o nican, etc.)	Specify: Whi				
Maryland 21215-0036	72 "ne	Completed	(Specify only highest grade completed) (Give	tent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	16b. Kind of Business/In	dustry			
12	e filed within at Hygiene. other then "vent, It e Mac	dwo	Flementary/Secondary (0-12) College (1-4or 5+)	rywall Mechanic		Self-Empl	oyed			
9	a the first		17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, M	Maiden Sumame)				
an	D 2 D 0	To Be	Michael E. Galuska Sr.	Est	her P	ackech				
ary	2 should I and Men is marke eumetic		1 1 21	ng Address (Street and Number or Ru						
_	alth 27 ar tr		\$ 101 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d 1 d 1	South Shore Road,	_					
Baltimore,	permit. Pages 1 a Department of Hez importent: If item any injury or othe		1 Burial 2 MCremation 3 Hemoval from State 1 _	natory or other place)		20c.Location-City or T Baltimore,				
Balti	permit. Departmit. Importe any inju		21. Signature of Fun- al Service Licensee 2	. Name and Address of Facility. cCully—Polyniak F 204 Mountain Road	uneral H , Pasade	lome P.A. na, Marylan	d 21122			
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
	Examiner	ner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying							
ú	cate be executed physicien and the burial-transit	Examine	that initiated events c							
68760,	ficate be physicients to the bur	edlcal	d							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Me		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year			
<u>α</u>	juires that n signed b ild be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tol	bacco use contribute to the second se	he cause of death?			
Records,	The law require tate has been signage 2 should t	Completed			24a. Was a autops perform	an 24b. Were autorsy prior to condeath?	opsy findings available impletion of cause of			
Vital		Be C	25. Was case referred to medical	26. Place of Dea	ath (Check only on		-0			
<u>></u>		0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing H	lome 5 Reside	ence 6 Other (Speci	(y)			
0	ding Phys n. After this funeral di	n: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 2b. Time of Inju			ow injury occurred				
ior	Attending ir death. ector: After by the fune	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No						
Division of	al or Atto s after de l Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	treet and Number or Aur n, State)	al Route Number,			
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. o the cause(s)			
	To the troining of troining of the troining of the troining of tro	29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. If gistrar's Signature MAR 0 8 2005								
1	OXPI		30. Name and address of person who completed cause of death (Item 23a) (Type, Wallish Markon 305)	Print) Hospital Dr.	Glen P	MD. 2	1061			
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 8 2005 32. Egistrar's Signature	book						

State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7:25 AM MARIE JOSEPHINE GARTON MARCH ath 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 F Director 217-12-9403 5/01/1909 MARYLAND Usual Residence of Decedent 10a State 10c City Town or Location 10d. Inside City Limits 10b County 7 is marked other than "naturel", or Itams 23a or 28e-f show treumetic event, ir e Modical Examitre mans the rivilling at 1 ☐ Yes 2 ☐XNo Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8315 LOCH RAVEN BLVD. APT. B 21286 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER BLACK & DECKER 6TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ould be fi CONRAD ZINKHAN OLIVE P. LEIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an VIRGINIA R. DERKOWSKI/FRIEND PARKVILLE, MD 21234 3 TEACHER COURT APT. F 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or o 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 3/12/2005 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral/Service Licensee hu 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part1. Enter the disease, or complications, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ESCHERICHIA COLI SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ganseouence offi Examiner certificate be executed HEART FAILURE DNGESTIVE attending physician and Due to (or as a consequence of) Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an ATRIAL AUTTER autopsy performed? 1 Yes 2 XNo Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☒Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death Division or Attending 5 Pending 1 Natural 1 ☐ Yes 2 No death. investigation after death Director: 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kunnilla, なん Res 000 MARCH 6th 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUTITH KULUVILLA, 5601 LOCH RAVEN BOULEVARD, BALTIMORE MD 21239 31. Date filed (Month, Day, Year) MAR 08 gistrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

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Records,

of

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	1- For State of Maryland / Department of Health and M Certificate of Death	ental Hygie	ZUU5 117636	
Physician	1. Decedent's Name (First, Middle, Last) James Alfred Gaglione, Sr.	2 Date of Death	3. Time of Death	
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NORTH Arundel HOSPIFAL Glen Burne		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 6. Sex 107. Age (In yrs. last birthday) 1104M 20 F 68 Yrs. 1104M 20 F 68 Yrs. 1104M 20 F	8. Date of Birth (Month, Day, You 10/29/19	9. Birthplace (State or Foreign Country)	
Aaryland I show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Glen Burnie		10d. Inside City Limits 1 ☐ Yes 2∑ No	
death with the Maryland ma 23s or 28s-1 show In ust be rediffed at neral Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?	
a 2 3 5	. If Yes, Give 1 □ Yes 2 X No Specify:	ocify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify:	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important: If frem 27 is marked other than "natural", or the any injury or other traumatic event, the Madical Examitia once. To Be Completed by Fu	3 □ Wildowed 4 □ Divorced Year or Dates: 1974	ng 16	White b. Kind of Business/Industry	
Ind 212 ind 212 be filed with tal Hygiene. d other than svent, then	Elementary/Secondary (0-12) College (1-4or 5+) Military 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Mai	U.S. Army	
Marylan Marylan nd 2 should be all and Merked to 27 is marked to a reaumatic sweet traumatic sweet to 20 merked to 20 merk	Gennaro Gaglione Clysta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	McGurk I Route Number, C	City or Town, State, Zip Code)	
ore, M ore, M ges 1 and 2 t of Health if I tem 27 or other tr		ate 200	e, Maryland 21060 c. Location - City or Town, State	
Baltimore Boartim Pages 1s Department of the Important: If them any injury or othe	`4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 20 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	05 Singletor	Crownsville, MD	
	23a. Part 1. Ether the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) LUNG CANCER (RECU	r respiratory arrest		
/Medical Examiner	resulting in death) Due to (or as a consequence of): The proof of th	•		
8760, ate be executed ate be executed thysician and the burial-transit	Sequentially list conditions, if any, leading to infimediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
8760 ate be hysicia the bur	d			
Division of Vital Records, P.O. Box 6is the Hospital or Attending Physician: The law requires that the death certificin 24 hours after death. The Fours after death The Fundation of the Control of the Control of the Fundation of the Fundation of the Fundation of the Fundation of the Fundation of the Control of the Cont	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year	
rds, P.(Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?	
Division of Vital Records, P.O. for Attending Physician: The law requires that the date death. Director: After this certificate has been signed by the fin by the funeral director, page 2 should be detached ertification; To Be Completed by Physic		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No	
of Vital Re- Physician: The la this certificate has ral director, page 2 ; To Be Comp	25. Was case referred to medical examiner? 1 Yes 2 Yoo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home		e 6 □Other (Specify)	
Division or To the Hospital or Attending Phi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	27. Manner of Death 1 Xivatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		et and Number or Rural Route Number,	
Di To the Hospital or within 24 hours aft To the Funeral bit completely filled in		and due to the caus	se(s) and manner as stated.	
To the within 2 To the comple	29b. Signature and title of certifier DOUGOS 2 4	29d.	Date signed (Month, Day, Year)	
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	itus PIDta	-, CRENBURNIFUL	
State Registrar	31. Date filed (Month, Day, Year) MAR 0 8 2005			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 4 2005 12:55A M March Ethel Elizabeth Glaeser /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 15, 1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2√XF MD 212-36-8377 91 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Items 23a or 28a-f show instrumet be notified at 1 ☐ Yes 2 XNo Completed by Funeral Director MD Linthicum Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 U.S.A. 806 Nursery Road death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Bleck, White, etc. the Medical Examiner: Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home traumatic evant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Sauter Harry Rau ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trae 524 Edric Drive, Linthicum, MD 21090 Mrs. Joyce H. Kleff / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town State 20a. Method of Disposition 1🌠 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Mar. 9, 2005 Elkridge, MD 4 ☐ Donation 5 ☐ ⊖ther (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. ment Service Lio nsee 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final unen YEAR Physician disease or condition resulting in death) /Medical Dus k (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? fo 4□Pregnant at time of death 5 Other (specify) 9 Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 76 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an has autopsy performe 1 ☐ Yes 25 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 🗌 Yes 2 10 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: the Hospital or Attending I hin 24 hours after death. After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral L 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120094 Burne ud, soo) 30. Name radison Park D me) Registrar's Signature State Registrar MAR 0 8 2005

			For State	State of Mar		artment of H				ene g. NQ	005	07600
			Registrar 1. Decedent's Name (First, Middle, La	ist)					2. Date of Death	Em	U U 3 -	3. Time of Death
	Physicia		Ray Vernon G	illey, Sr.					Month MARCH 0	Day 1. 2	OO5	5:00 P M
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or	r Location of	of Death		4c. C	ounty of Death	1
			SAINT JOSEPH MEI				WSON_				BALTI	
	Funeral	- 1	, , ,	17DM 200E	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	3. Date of Birth (Month, Day,		h~ 17	place (State or Foreign intry)
	Director		239-14-2111	84	TIS.			J	une 7,	1920) Nort	h Carolina
	and and		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation						10d. Inside City Limits
	Many -f sh	ctor	Maryland Harford	a l	Bel A	ir						1 ☐ Yes 2 🔀 No
	r 28e	Direc	10e. Street and Number			10f. Zip Code			10	g. Citize	of What Cou	untry?
	h witi	a D	1903 Wheel Road	i .		2101	5				USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H	lispanic Ori an, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14	I. Race - Amer Black, White	
0	or the		1 Never Married 2 Married	1X Yes 2 □ No		1 ☐ Yes 2 No	Specify:			S	pecify:	r.al - 2 + -
2-003c	within 72 hours after death with the Maryland jien. Jien. Then "neturel", or items 23a or 28e-f show the "Maryleal Examiner must be notified at the Maryleal Examiner must be notified at the Maryleal Examiner must be notified.	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 1 9		dent's Usual Occup	ation		T 1	6b Kind	of Business/li	White
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Z		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Carpe	enter				Co	nstruc	tion
0	be filed ital Hygi od other event, I	a	17. Father's Name (First, Middle, Las	t)	<u> </u>		18. Mothe	er's Name	(First, Middle, M	laiden S	umame)	
yland		Fo B	James Lester G	illey			Vil	lar	Victori	a B	Barr	
Mary	2 short and h ls ma	-	19a. Informant's Name/Relationship	(Турө, Print)	19b. Maili	ing Address (Street	and Numbe	er or Rural	Route Number,	City or	Town, State, Z	ip Code)
-	rtt r		Venia L. Gilley	/ Wife		3 Wheel R	oad,	Bel A			nd 2101. ation - City or 1	
	ges 1 a of Hea If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State		matory or other place Memorial			-5-05 A		1	
	tmen tent: tent:		'4 □Donation 5 □ Other (Spec							LULI.	io, nar	yrand
Банттог	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Lice	M. all	Í	2 Name and Addre 1000mas F 1317 Coke	unera spurv	I Hom	e, P.A.	don,	Maryla	and 21009
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the	ne death. Do not en	_						Approximate Interval Between
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	/Medical		resulting in death)	d	consequence of):				- 17			
	Examiner		Sequentially list conditions.	D	GENIC SHO	CK						HOURS
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):	VOGADDIAI	T NTT A	D CTT C	ANT			HOURS
	and I-tran	Examiner	that initiated events resulting in death) Last	U	MASSIVE M consequence of):	YOCARDIAL	INFA	IKCIIC	JN .			HOURD
8/60,	certificate be executed nding physician and use as the burial-transit			,	, ,							
68/	ficate physis the	edical		0.						145		
Rox	eath certifica attending ph for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy	Ectopic pregnanc				23	d. Date of deli	,
ň	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		Other (specify)	у				Month	Day Year
О	that fhe de led by the a detached t	hys	9 ☐ Unknown	9L Unknown								-1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -
	Se Ju	by F	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part	1.	23e. Did tob	\	(the cause of death?
ord	w require been sign										1140 3 FT	obably 4 Donkhown
Records,	has be	Completed							24a. Was ar autops perform	/	24b. Were au prior to death?	topsy findings available completion of cause of
	The cate h	Cou							1 ☐ Yes 2		1 Yes	2) No
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	205		(Check only one			
	Physi this o	10	1 Yes 2 No 27. Magner of Death	28a. D te of Injury		ALL SEL DON	4 🗀 14		ne 5 Reside 8d. Describe ho			cify)
Division of	ding F h. After funer	lon	1 Natural 5 ☐ Pending	(Month, Day	Year) Injury	Wo	rk?]Yes 2□		od. Dosonbo no	injury	00001100	
S	Attending Physician: ir death. ector: After this certific. by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injur	y - At home, farm, s	treet, factory, office	-	2			Number or Ru	ıral Route Number,
<u>≥</u>	ospitel or A hours after uneral Dire ly filled in by	Certification:	4 - Homicide	building, etc.	(Specify)				City or Town	, State)		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier 1 Cartifying I	Physician: To the best of aminar: On the basis of e	examination and/or i	th occurred at the ti	ime, date a opinion, de	nd place, a ath occurre	nd due to the ca	use(s) a ate and p	and manner as place, and due	stated. to the cause(s)
	To the Ho within 24 To the Fu	Medi	one)	and manner state	ed.	29c. Licen					signed (Month	
1	To To	-	29b. Signature and title of certifies	51141111	MAR	D 35				31.	100	
•	- 11		30. Name and address of person wh	o completed cause of do	ath (Item 23a) (Tyro					11	1-7	
	10+1				ER DRIVE		MARYT.	AND 2	1204			
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DHMH 17 Rev 1/2001

			1 - For State Registrar		artment of Health and M		ene 005	07639			
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death			
	/Medic		Lorraine Carol	Gearhart		MARCH	4 2005	108 P M			
4	Examin	er	4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Death		4c. County of Death				
			33 Green Street 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Aberdeen If Under 1 Year If Under 24 Hrs.	O Date of Birth	Harford	(0)			
п	Funeral Director		363-56-5191	58 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 7,	Year) Coun 1946 Mary	lace (State or Foreign try)			
			Usual Residence of Decedent	36		000. 7,	1940 Mary	Land			
	how		10a. State 10b. County	10c. City, Town or Lo	ocation	· ·	1-	Od. Inside City Limits			
	e Ma	cto	Maryland Harford	Aberdee	n			1 XYes 2 □ No			
	or 28	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coun	try?			
	within 72 hours after death with the Maryland liene. r then "neturel", or ttems 23e or 28e-f show the Medical Examinar must be notified at		33 Green Street		21001		USA				
	tems	Funeral	Am	s Decedent Ever in U.S. 13. ned Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,				
36	s afte	by Fi	If Y	Yes 2 DXNo es, Give	1 ☐ Yes 2 【XNo Specify:		Specify:				
8	hour turel	pa pa	15. Decedent's Education	ar or Dates:	deat's Heuri Cocupation	1 4		nite			
15	in 72 " ne	Completed	(Specify only highest grade comp	leted) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng "	6b. Kind of Business/Inc	lustry			
212	d within jiene.	шо	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	gar Packer		ugar Proces	ssina			
Þ	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name						
<u>a</u>		To B	John (nmn) I	Pulver	Elsie	Lorrai	ne Work	inger			
Maryland 21215-0036	es Drait		19a. Informant's Name/Relationship (Type, Prid	nt) 19b. Maili	ng Address (Street and Number or Rura	l Route Number,	City or Town, State, Zip	Code)			
	s 1 and 2 of Health a item 27 ts other tree		Tammie Reeder - Daugh	iter 8764	Old M/78, Haslett	MI 488	40				
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)		Oc. Location - City or To				
Ei m	Pag tment tent: jury		`4 ☐Donation 5 ☐ Other (Specify)	Bel Air	Mem. Grdns 3-9-		Bel Air, Ma				
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	1	Name and Address of Facility McComas Funeral H 1317 Cokesbury Ro	ome, P.A		0001C Fee			
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only onle caus	that caused the death. Do not en	ter the mode of dving, such as cardiac of	r respiratory arres	gdon, Maryl	Approximate			
			shock, or heart failure. List only one caus Immediate Cause (Final	e on each line.	1. to 0	D	1	Approximate Interval Between Onset and Death			
	Pnysician /Medical	resulting in death) Due to (or as a consequence of):									
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687	ficate physis the	edical	d								
Вох	eath certific attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If ye	es, outcome of pregnancy			23d. Date of delive	ry			
	death	Physician/M	in the past 12 months?	Pregnant at time of death 5[□Ectopic pregnancy □ Other (s <i>pecify</i>)		Month	Day Year			
P.0	that the de led by the a detached t	hys	9 DE UNKNOWN	Unknown							
	o do	by	Part II. Other significant conditions contribution	g to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the				
ord	w requir been si should	eted	None			1 ∐ Yes	2 万No 3 ☐ Proba	ably 4 Unknown			
of Vital Records,	law 2 s	omple				24a. Was an autopsy	prior to con	sy findings available pletion of cause of			
프	Th ate pag	Col				performe		2 🕱 No			
Vit.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		26. Place of Death						
o		- To	TON THE ZUNO	1 ☐ Inpatient 2 ☐ ER/Outpatien Date of Injury 28b. Time of	11 3 DOA 4 Nursing Hor	ne 5 🗶 Residen 28d. Describe how	ce 6 ☐Other (Specify)			
O	ding th. Th. funer	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		mary coodina				
Division	or Attending after death. Director: Aftel in by the fune	ertification;	3 ☐ Suicide 6 ☐ Could not be 28e.	Place of Injury - At home, farm, st	reet, factory, office		et and Number or Rural	Route Number,			
	in the	Cert	4 Homicide	building, etc. (Specify)		City or Town,	State)				
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical ((Check only 2 Medical Examiner: Or	the basis of examination and/or in	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cau	se(s) and manner as sta e and place, and due to	ited. the cause(s)			
	thin 2 the I mplet	Med	one) and 29b. Signature and title of certifier	d manner stated.	29c. License number		d. Date signed (Month, D				
	Z × Z		A a III	. A () 2							
,	1		30. Name and address of person who complete	d cause of death (Item 23a) (Time	D14206	1,4	1 arch 5, 20	005			
	φ		• /		Road, Bel Air, Ma	ryland 2	21014				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	la.						
	Registr	ar	MAR 0 8 2005	which the special							

EKE	SE HUN	.EK	State of Maryland / Department of Health and Mental Hygiene 1- For Unpend Item 23a&27 per me G841 3-11-05 tas 1- For Unpend Item 23a&27 per me G841 3-11-05 tas Reg. No.	07640
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
	/Medic	al .	march 2, 2005	0905 A M
	Examin		6401 LOCH RAVEN BLVD. API. 423 BALTIMORE CITY N/A	
	Funeral Director		5. Social Security Number 136-09-4865 Usual Residence of Decedent 6. Sex 1	ice (State or Foreign y) W Jersey
)	yland yland			d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	ctor	Maryland N/A Baltimore	1X Yes 2 □ No
	ih th or 28	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr	y?
	s 23s	ra	6401 Loch Raven Blud., Apt. 423 21239 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	n Indian
		by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No II □ Yes 2 ▼ No Specify: S	tc.
5-0036	72 hours atter natural', or ite	Completed b	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	
121	within ene. than "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	0
121	illed w Hygie ther t			Company
Maryland	12 should be filed within " h and Mental Hygiene. 7 is marked other than " raumatic event, the Mass	To Be		
lan	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	Code)
ص ص	ss 1 and 2 of Health item 27 i		Bea Simmons (Friend) 3227 Dogwood Drive St. Four VA 24283 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Tow	n State
Jor	ages nt of h t: tf ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	
Baltimore,	permit. Pages Department of the important: If ite any injury or or or once.		*4 Donation 5 Other (Specify) Holly Hill Mem. Gdns 3/05/2005 Baltimore, Ma 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home	Tuc
B	Depar Impo any ir		3331 Brehms Lane, Baltimore, Maryland 2	1213
	Physician /Medical Examiner	lner	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Onset and Death
68760,	centiticate be executed adding physicien and use as the burial-transit	dical Examin	resulting in death) Last Due to (or as a consequence of): d	
P.O. Box (that the death certitics ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	/ Day Year
	Se US 90	by	rate in other arguments conditions contributing to death but not resulting in the underlying cause given in rate.	
Vital Records,	The law ate has b page 2 sl	Completed	24a. Was an autopsy performed? 1 12 Yes 2 □ No 1 2 Yes 2	sy findings available pletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	examiner?	at gaana
of	Phys rthis ral di	n: To	1 Inpatient 2 EMOutpatient 3 DOA 4 Nursing Home 5 Hesidence Author (Specify)	at scene
ion	Attending I r death. ector: Atter by the funer	atlo	1 X Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
Division	or Atterater de Directo	Certification:	2 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural factory, office building, etc. (Specify)	Route Number,
_	To the Hospital or Attendi within 24 hours atter death. To the Funeral Director: A completely tilled in by the fu	edical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	To the To the Comp	W	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date MARCH 3, 200)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, HP 111 Penn Street Baltimore, Maryland	1 21201
	Sta Registi		31. Date filed (Month, Day, Year) 22. Registrar's Signature	

		1 - For State of Maryland / Depart Cert	rtment of Health and Me rificate of Death	ental Hygier	2000 07641								
Physic	ian	1. Decedent's Name (First, Middle, Last) Mildred E. Hartnett		2. Date of Death Month	3. Time of Death Day Year 1:12 F M								
/Med Exami			4b. City, Town, or Location of Death		4c. County of Death Baltimore								
Funeral Director		212-05-1899 TOM 201 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye, Jan. 01,	ar) 9. Birthplace (State or Foreign Country) 1909 MATYLAND								
yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits								
ne Mar 8a-fal	ctor		wson		1 ☐ Yes 2 ☑ No								
3a or 2	i Dir	10e. Street and Number 20 Dunvale Road, Apt. 205	10f. Zip Code 21204	10g.	Citizen of What Country? U.S.A.								
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic avant, it a Madical Evaniran must be notified at anones.	y Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. If Maried Forces? 1 Never Married 2 Married In Yes 2 Mo If Yes, Give	Second of Hispanic Origin? (Specy Yes, specify Cuban, Mexican, Puerio F Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White								
2 hours	ted b	15. Decedent's Education 16a, Decede	int's Usual Occupation	16b	Kind of Business/Industry								
Man 'n	Completed by	Elementary/Secondary (U-12) College (1-4or 5+)	ind of work done during most of workin O NOT use retired)		To Paralague Commence								
d 21 filed w Hygier othar ti	e Co	8th Grade Switc. 17. Father's Name (First, Middle, Last)	hboard Operator 18. Mother's Name		Telephone Company on Sumamo)								
Vlan	To Be	George Imhoff	Mary	Vaugha	n								
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or any highy or other traumatic awant, tra Madical Exert applies.			Address (Street and Number or Rural Sabina Avenue, Ba										
or Heal		20a. Method of Disposition 20b. Place of Disposition			Location - City or Town, State								
timent trant: ff tant: ff		*4 Donation 5 Other (Specify) Parkwood	Cemetery 3/9/0		ltimore, Maryland								
Dal permii Depar Impor any Ir			Name and Address of Facility Sch 705 Belain Rd. Bo										
		23a Jan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Shock, or heart failure. List only one cause on each line.											
Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onset and Death								
Examiner	ı		FECTION										
p ₀ tis	iner	Sequentially list conditions, and the conditions of the cause. Enter Underlying Cause (Disease or injury											
58760, / / retate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last c. ACUTE RENAL FAIL Due to (or as a consequence of):	URE										
8760, cate be ex physician the buria	edicai	d											
Geath certif	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year								
Records, P.O The law requires that the ste has been signed by th	þ	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?								
Vital Records, sician: The law requires to certificate has been signification, page 2 should be.	Completed			24a. Was an autopsy performed.									
of Vita Physician: rthis certifica	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death										
Of Phys rathis	n; To	27. Manner of Death 28a. Dale of Injury 28b. Time of	3 DOA 4 Nursing Hom	e 5 Residence 8d. Describe how in	6 ☐ Other (Specify) jury occurred								
Division of attending Fatter death. Director: After din by the funer.	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No										
Divisit	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office 28	8t. Location (Street City or Town, St	and Number or Rural Route Number, ate)								
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant manner stated.	occurred at the time, date and place, an stigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. and place, and due to the cause(s)								
To tha within 2.	Σ	29b. Signalure and title of certifier Mellie m. 0	29c. License number	29d. [Date signed (Month, Day, Year)								
0		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	D4141Ø	111	mer 22 , 2002								
57		JOGINDER P. MEHTA.M.D. 7601 O	SLER DRIVE, TOU	ASON, ME	RYLAND 21204								
St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 8 2005 32. egistrar's Signature	we										

		1 - For State Registrar	State of Maryla		artment of rtificate o			Rag. No.	07642
Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Do Month	aath Day Year	3. Time of Death
/Medi		Richard L. Howell					March	6, 2005	11:05 PM M
Examir	ner	4a. Facility Name (If not institution, give s				, or Location of De	ath	4c. County of Deatl	1
-		Laurelwood Nursing 5. Social Security Number 6. Sex		ltation . last birthday)	If Under 1 Yea	Elkton ar If Under 24 H	rs. 8 Date of Bi	Cecil	nplace (State or Foreign
Funeral Director			M 2□F 68	Yrs.	Months Day				untry)
yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
ith the Marylan or 28a-f show	ctor	DE New Cast	leNe	wark					1 ☐ Yes 2 No
or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
ath w	rall	1172 Elkton Road 19711					United Stat		
ITE; INTALYIGITION ZINIONOSO 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. 1 the marked other than "natural", or items 23e or 28e-f show other traumatic event, ITE Marical Expr. IDMIT WELLER IN IDMI	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put				(Specify Yes or No erto Rican, etc.)	14. Race - Ame Black, White		
rs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specity:					Specify:		
2 hou	ed	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occ	upation		Whi 16b. Kind of Business/l	
Din 22	ple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)				vorking	Education		
Z I Z I 3-0030 ad within 72 hours af giene. ar then "natural", or	Completed	Elomoniary, coconstany (o 12)	5+	Teach	er				
Maryland 2 1 2 d 2 should be filed with th and Mental Hygiene it is marked other the traumatic event, IPE	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maiden Sumame)	
should be and Ment s marked umatic a	To	Millard L. Howell		F10.00		Dorothy	y Lathom		
and and is my		19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Stre	et and Number or i	Rural Route Numb	er, City or Town, State, Z	ip Code)
Dallingrey IN permit. Pages 1 and 2 Department of Health Important: if item 27 i any injury or other tra	1	Beverly A. Howell /				Road New		19711	
Dallimore, Darmit. Pages 1 a Department of Her mportant: if item any injury or otha		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ R		cemetery, crer	sition (Name of natory or other p	lace)	Date Mar 8	20c. Location - City or 1	fown, State
parmit. Pag Department Important: i any injury o		'4 ☐ Donation 5 ☐ Other (Specify)			ke Crema		2005	Beltsville,	Maryland
Dallill parmit. Pa Departmer Important any injury	- Andrews	21. Signatur of Funeral Survice License	Broam j	C 22	. Name and Add remation	ress of Facility and Fune	ral Alter	natives	
		23a. Part1. Enter the disease, or compli	cations that caused the dea	8	717 Gree	n Pasture	s Drive	Baltimore, Ma	ryland Approximate
Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Due to (or as a conse	S7466		to ones s			Interval Between Onset and Death
sate be executed shysician and the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):							
The Colus, F.C. Box 00/00, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		in the past 12 months?	3c. If yes, outcome of pregr 1	al death 3 ☐	Ectopic pregnar	ncy		23d. Date of delin	very Day Year
that the dead by the detached	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	464II 3L	Tottlet (specify)				
quires that the signed by	by	Part II. Other significant containions contributing to death but not resulting in the underlying cause given in Part I.							the cause of death?
II necolus, The law requires t sate has been signe page 2 should be	Completed						24a. Was auto perfo		opsy findings available ompletion of cause of
	O	25. Was case referred to medical		·		26. Place of D	eath (Check only o	f	22.110
Q io Q	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA	other: Mursing	Home 5 ☐ Resi	dence 6 ☐Other (Spec	ify)
After funer		27. Manner of Death Matural 5 Pending investigation 3 Suicide 4 Homicide Minimal Min							
LIVISION all or Attanding s after death. al Director: After ad in by the fune	Certifica								
To the Hospital or Attant within 24 hours after dealt To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Cartifying Phys (Check only one) 1 ☐ Medida Examir	icin: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and place opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To ti Withi To ti	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Month)	
/		1 / 1/1/9	DW m		CIC	1514001		07 Mar 0	5
5		30. Name and address of person who co	817 C	HURCH	Print)	CTR	NEW	OTMORO	19720
Sta Regista	1	31. Date filed (Month, Day, Year) MAR 0 8 20	32. Pegistrar's Sign	ature	المان				

			1- State of Marylan State of Marylan	-	artment of H			iene eg. No.	105	07643	
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month					3. Time of Death	
	Physicia /Medic		Daniel William Hi	el William Hirsch			March 4			11:50 AM	
Examiner			4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of D	eath		4c. County of Death		
			Riverview Care Center	to as bindbalasis	Es If Under 1 Year	SeX	dec la Day (Pint		alti		
ķ	Funeral Director		5. Social Security Number 215-80-4306 6. Sex 1 M 2 □ F 7. Age (In yrs. 44		Months Days		fin. B. Date of Birth	, ^{ve} 1960	$0 Ma^{0.800}$	thplace (State or Foreign bunta) ryland	
	and w	Director	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If flem 27 is marked other than "natural", or Itams 23a or 28a-f show	Aaryli f sho		Maryland Baltimore		Balti	more				1 Yes 2 No	
	28a-		10e. Street and Number		10f. Zip Code	1	0g. Citizen	of What Co	puntry?		
	3a or		49 Blister Street		2.1			USA			
	deatl	To Be Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Force	S. 13.			(Specify Yes or No- uerto Rican, etc.)			erican Indian,	
	urs after II', or Ite		1 □ Never Married 2 1 ☑ Married 1 □ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	t t	1 □ Yes 2 No	Specify:	zorio i riozri, etc.,			nite	
ğ	2 hou		15. Decedent's Education		dent's Usual Occup		wadiaa	16b. Kind o	of Business	Industry	
27.	thin 7 e		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	lite.	DO NOT use retired	1)					
7	ed wi		12	Maint	enance T			_	sing l	nome	
Maryland 21215-0036 d 2 should be filed within 72 hours af	be fil htal H ed otl		17. Father's Name (First, Middle, Last) Robert F. Hirsch				Name (First, Middle, 1 Arbara Ann		name)		
2	hould d Mer marke matic		19a. Informant's Name/Relationship (Type, Print)	19h Mailir	on Address (Street		ILDALA AIIII Rural Route Number		wn State	Zin Code)	
Mai	and 2 s		Robert F. Hirsch, Jr./brother				Kingsville				
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other trau once.		1 ☐ Burial 2 M Cremation 3 ☐ Removal from State	emetery, crei	sition (Name of matory or other place	· 1			•	Town, State	
altin	rmit. P. partme portani y injury		A Donation 5 Other (Specify) Metro Crematory, Inc. 3/5/05 Baltimore, MD 21. Signature of Fun. al Service Licensee Cremation Society of Maryland, Inc.								
<u> </u>	8258		Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228								
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final								
	Physician /Medical	ner	disease or condition resulting in death) Due to or as a consequence of the condition of th		ateral	nae	520412			& MENUTES	
	Examiner			201100 017.							
7	n =		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):							
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events c.						_		
8760,	ate be executed hysician and the burial-transit	E	resulting in death) Last Due to (or as a conseq								
687	ate hy the	dicai	d								
	death certifica s attending ph d for use as t	J/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					23d.	23d. Date of delivery		
. Box		Physician/Me						Month		Day Year	
Ö.	that the de ed by the detached	hys	9 Unknown								
S B B	uires tha signed id be de	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Miknown			
COL	w requir been si should	iete					24a. Wasa	n 24	4b. Were au	topsy findings available	
Division of Vital Record	The lav	omp					— autops perform 1 ☐ Yes	med? 2 W No	death?	utopsy findings available completion of cause of 2□ No	
ta		O	25. Was case referred to medical			26. Place of	Death (Check only on				
f <	Physiclan: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 Dursin	ig Home 5 ☐ Reside	ence 6 🗆	Other (Spe	cify)	
n 0	ng Pl										
sio	ttendi death. ctor: A / the fu	cati	2 Accident investigation			Yes 2 □ No	ORG Leasting (Co	28f Location /Street and Number or Dural Pouts Number			
Ξ	l or At after o Direc I in by	Certification;	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specification of the control		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific compisiely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death o	ccurred at the time, d	ate and pla	ce, and due	to the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of certifier		29c. Licens	e number				h, Day, Year)	
1	/		Mileael Yourand		D19	667		Marc	h 4,	2005	
	5	,	30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	Locus de	508 aleu	Borris	e Ma	10015 kg/h	
	Sta		31. Date filed (Month, Pay, Year) 32 legistrar's Signa		and I				7 0		
	Registi	ar		- 7			- 4				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) February 24,2005 Hamlett **Physician** Htward /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Hunder 1 Year Hunder 24 Hrs. 8. Date of Bir Prince George luursing Henium 9. Birthplace (State or Foreign Charlotte County) Age (In yrs. last birthday) 5. Social Security Number 227 - 22-7966 82 Months Days Hours 12 M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No torestvil Funeral Director 10g. Citizen of What Country? 10e. Street and Number United States Mariboro 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indien Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Black Specify Specify: ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Employed Elementary/Secondary (0-12) College (1-4or 5+) aybor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madison Hamlett Gordon alah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 3023 Sunset Lane Blalock 1sister Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) **Date** 20c. Location - City or Town, State 20a. Method of Disposition Brentwood, MD 3/4/05 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Austin Rouster Funeral Home 3821 14th St. NW Washington, DC 21. Signature of Funeral Service Scensee 20011 En or the Hisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER FLOOR OF MOUTH Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) edical Certification; To Be Completed by Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? SEIZURE DISORDER 2 1 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requiras that the de within 24 hours after death.

To the Funeral Director: After this certificata has been signed by the completaly filled in by the funeral director, page 2 should be datached

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with tha Maryland nent of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0020

nt of Health and Mental Hygiene.
If Nem 27 Is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Medical Examiner must be notified at

Department of Health a Important: If Item 27 is any injury or other trains

Physician /Medical

Examiner

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 I Homicide

29a. Certifier

tttending physician

29c. License number

29d. Date signed (Month, Day, Year) 3-4-2005

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

8700 CENTRAL AU #301, LANDOVER MD 20785 MOMOH MD MUSA 31. Date filed (Month, Day, Year)

State Registrar

MAR 0 8 2005



		For State	State of Mar	-				•	711115	07645	
		1 - State Registrar AMEND TTEM 1. Decedent's Name (First, Middle, Last)	#20b PER 1	PH G841	3/08/	65 Jipe	alli	2. Date of De	Reg. No.	2.7:	11-
Physi	cian		HARF					Month	Day	Year ZOOS 8 - 45	
_/Mec		505AN 4a. Facility Name (If not institution, give s		<u> </u>	4h Ci	y, Town, or Loca	ation of Doath	MARC	4c. County		7-1 IVI
Exam	iner				40. 01	y, TOWN, OF LOCA		/son	4c. County	_	
Funoro		5. Social Security Number 6. Sex	lealth Center-T	OWSON In yrs. last bir.	thday) If Unc	ler 1 Year If C	Jnder 24 Hrs.	8. Date of Bin	th	Baltimore 9. Birthplace (State or F	Foreign
Funera Directo			M a∏F	-	Yrs. Month	s Days Ho	ours Min.	(Month, Da	y, Year)	Birthplace (State or F Country)	Uraigir
		Usual Residence of Decedent		70				Jun 1	l, 1934	N.C.	
larylan show		10a. State 10b. County	1	oc. City, Town	n or Location					10d. Inside City t	
e Ma	cto	Maryland N/A	\			Baltim	ore			1 X Yes 2	□No
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itams 23a or 28a-f show event, Ita Moulcal Exp. in a final tall and	Director	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of	What Country?	
72 hours after death w "natural", or Itams 23a	Funeral	301 McMechen Street					21217			U.S.A.	
er de tams	nue		Was Decedent Ev Armed Forces?		13. Was Dec	pedent of Hispan pecify Cuban, Me	nic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Bla	ce - American Indian, ck, White, etc.	
S afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X		1 ☐ Yes	2 No Sp	ecify:		Specif	y: Dlask	
hour		15. Decedent's Educ	Year or Dates:	162	Decedent's He	sual Occupation			16h Kind of B	Black	
in 72	Completed	(Specify only highest grade	completed)		(Give kind of v	vork done during	g most of wor	king	100. KING OF B	usiness/Industry	
thar thar	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			Nurs	e		Hender	rson State Hospita	al
be filed within 72 hould have the mature of other than "nature ovent, it was a modern of the modern	0	17. Father's Name (First, Middle, Last)					-	ne (First, Middle,	Maiden Surnar	ne)	
	ToB	Fleming Mo	Cullough					Lucille	McCullou	ıgh	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, It a Mary injury or other traumatic event, It and It		19a. Informant's Name/Relationship (Typ	ne, Print)	19b	. Mailing Addre	ss (Street and N	Number or Ru	ral Route Numbe	er, City or Town,	State, Zip Code)	
and 2 salth a n 27 ls		Donna Tolbert			1 Bleech	ner Terrace	Apt 218	Albany, N.	Y. 12206		
other other		20a. Method of Disposition		20b. Place of cemeter	Disposition (A	lame of r other place)	2 /0	Date 5/05	20c. Location	City or Town, State	
Pages nent of int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State			orial Garde	!	0 3/03/05	Baltir	nore, Maryland	
permit. Departn Importa any inju	9	21. Signature of Funeral Service License	ө	11011		and Address of					
3 80E 8 8	3	23a. Part J. Enter the disease, or complic	of the same of the		9	step Broth	ers Fune	ral Svc	1 04047		
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line.	e death. Do r	not enter the m	ode of dying, su	ch as cardiac	or respiratory a	rest,	Approximate Interval Between	en
Physician	1	Immediate Cause (Final disease or condition	CEREB		15001	-AR	ACC	FOLL	NY	Onset and Dea	ath
/Medica		resulting in death)	Due to (or as a						· 1	month	^_
Examine		Sequentially list conditions	CORO Due to (or as a c	NAR	Y A	RYER	YD.	SEAS	E	monu	To
ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0								
ecute and trans	cam	that initiated events cresulting in death) Last				MBOLI	SM		···	monu	~
cian courial		and the second s	Due to (or as a o	consequence	or):						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai	d									
eath certific attending p	Physician/Me	IF FEMALE:	3c. If yes, outcome of	nregnancy							
atten for u	ian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin	Fetal death	3 □Ectopic 5 □ Other (te of delivery Inth Day Yea	ar.
he de ched	ysic	1 Yes 2 No	9□ Unknown	ne or death	5 ☐ Other (specily)					
w requires that the de been signed by the should be detached		Part II. Other significant conditions con	tributing to death but	not resulting in	the underlying	cause given in	Part I.	23e. Did t	obacco use cont	ribute to the cause of deat	th?
uires sign Id be	d by					•		10	res 2□No	3 Probably 4 □Unk	inown
v req	Completed							24a. Was	24h	Manager diagram	-1-61-
he lav	dm							autor	sy	Were autopsy findings ava prior to completion of caus death?	se of
ilcian: Th certificete rector, pag	e Co	OF Was assessed to madical						1 Yes	2.2 No	1 ☐ Yes 2 ☐ No	
yaician: The is certificete hadirector, page	o Be	25. Was case referred to medical examiner?	ospital:	0 □ ED/O		0.4	-	th (Check only o			
Phys r this sral di	h-	27. Manner of Death	1 Inpatient 28a. Date of Injury	28b. 1	tpatient 3 [JOA	Nursing Ho	ome 5 ☐ Resid	dence 6 UOth		
dlng th. Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y		njury M	28c. Injury at Work? 1 ☐ Yes	2 No				
Atter dea	ertifications	3 Suicide 6 Could not be	28e. Place of Injury	- At home, fa	rm, street, facto	ory, office		28f. Location (S	Street and Numb	per or Rural Route Number	r,
after after din b	erti	4 Homicide	building, etc.	(Specity)				City or Tov	vn, State)		
splta nours nera / fille	a C	29a. Certifier 1—Certifying Phys	ician: To the best of r	my knowledge	, death occurre	d at the time, da	ate and place,	and due to the	cause(s) and ma	inner as stated.	
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examin	er: On the basis of exand manner state	xamination an	d/or investigation	on, in my opinior	n, death occur	red at the time,	date and place,	and due to the cause(s)	
To th Withir To th	M	29b. Signature and title of certifier			2	9c. License nun	nber		29d. Date signe	d (Month, Day, Year)	
^		5	pupte a	1D		D00	5 31	50	MARC	Hand 200	5
13	-	30. Name and address of person who con	npleted cause of dea	th (Item 23a) (
1		30. Name and address of person who co	= GUDY	S MI) 77.	00 401	RUR	D PC	NOSCX	ND 5150	14
S	tate	31. Date filed (Month, Day, Year)	. Hegistrar	s Signature	A. A.						
Regis	trar	MAR 0 8 2005	Fig.	18%	A STATE OF THE PARTY OF THE PAR						

			1 - For State Registrar		State of M	aryland / I		artment of F tificate of	Health and N <i>Death</i>	Mental Hy	giene	005	07646
	Physici		Decedent's Nam	e (First, Middle, Las	,	na E. Ho	wa	rd		2. Date of D		05	3. Time of Death 7,00 A M
	/Medic Examir Funeral		4a. Facility Name (in Frankling) 5. Social Security N	2 Square	street and number)			4b. City, Town, o	Le If Under 24 Hrs.	8. Date of Bi	4c. Co	unty of Death	
	Director		216-54- Usual Residence o	2/51	□м 2√Г г	56	Yrs.	Months Days	Hours Min.	(Month, D Feb 2	ay, Year) 4, 1949		Maryland
	aryland show	_	10a. State	10b. County		10c. City, Tow	n or Lo						10d. Inside City Limits 1 X Yes 2 □ No
	the Mi	Director	Maryland 10e. Street and Nu	L	more			10f. Zip Code	atonsville		10g. Citizer	of What Cou	
	th with 23a or	al Di	6 Half Pen	ny Lane					21228			U.S.	A.
036	init. Pages I and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. Orfant: if item 27 is marked other than "natural", or itams 23a or 28a-f show injury or other traumatic event. I'm Medical Examinat must be notified at a.e.	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2 🙀 Married 4 ⊡ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:)		Vas Decedent of H Yes, specify Cuba □ Yes 2 (1) No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)		Race - Amer Black, White ecify:	
Howard, Veltina	in 72 ho	Completed		15. Decedent's Ed	de completed)		. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retired	pation during most of work d)	ing	16b. Kind	of Business/li	ndustry
oward, Veltina	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, the Negonce.	Com	Elementary/Seco		College (1-4or !	5+)		Sale	s Person			Ret	ail
161	ld be fil ental H kad otl ic ever	To Be	17. Father's Name	(First, Middle, Last) Thomas	s Jones				18. Mother's Nam		thel Jor		
A Sarv	2 should and Men is marka	-	19a. Informant's N	ame/Relationship (7	ype, Print)	198			and Number or Rur				p Code)
ALL IN	1 and Health tem 27		Desiree Op 20a. Method of Dis			20b. Place of	f Dispo	sition (Name of	Street Baltim	ore, Maryla Date		3 ion - City or T	own, State
	Pages nent of ant: if i			☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State)	cemete		natory or other place stern Cemete		03/11/05	Ва	altimore,	Maryland
Hall	permit. Departr Importa		21. Signature of Fu	ineral Service Licen	200		22	Name and Addre	rothers Fune	al Service		04047	
					olications that caused one cause on each li	d the death. Do		er the mode of dyin		or respiratory a	arrest,	21217	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final	a. Met Due to (or as	astat a consequence	-1C	breast	- CANCE	<u> </u>			
	Examiner	er	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate	b. Due to (or as	a consequence	of):						
64	ecuted and transit	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death)	3	с.								
68760	ficate be executed ficate be executed physician and is the burial-transit	edical E			d.	a consequence	or).						
	ertificat ling phy e as th	Medi	IF FEMALE:		00.14								
O. Box	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physiclan/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	/		23d	. Date of deliv Month	very Day Year
rds. P	w requires that been signed I should be det	by	Part II. Other signi	ficant conditions co	ontributing to death b	out not resulting	n the ur	derlying cause giv	en in Part I.		tobacco use Yes 2 □ N		the cause of death?
Division of Vital Records. P.O.	The law recate has be page 2 sho	Completed								24a. Was auto perfo 1 Tyes		4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
Vita	yaiclan: The is certificate director, pag	Be	25. Was case referexaminer?	,	Hospital: 1 Inpatie	2 T EB/O	-tent-on	t 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho			10th = 1 (C	* 1
ם ס	ding Phys h. After this funeral di	on: To	27. Manner of Deat		28a. Date of Inju (Month, Da		Time of Injury	28c. Injur Wor	y at k?	28d. Describe			197
vivio	or Attendi after death. Diractor: A lin by the f	Certification;	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Place of Inj	jury - At home, fa	arm, str	M 1 [Yes 2 □ No	28f. Location (Street and N wn, State)	umber or Rur	al Route Number,
	To the Hospital or Attenwith 24 hours after deatl To the Funeral Diractor: completely filled in by the		29a. Certifier	Certifying Phy	ysician: To the best	of my knowledg	e, death	occurred at the tir	ne, date and place,	and due to the	cause(s) and	d manner as s	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 29b. Signature and	2 Medical Exam	iner: On the basis o and manner st	if examination ar	nd/or inv	estigation, in my o	pinion, death occur	red at the time,	date and pla	gned (Month,	to the cause(s)
	T Wil	_	b Signature and	Suax	gr mo			DO	053641		3.	6.0	5
	3		30 Name and di	e Juan	ompleted cause of c	death (Item 23a)	(Type,	ran Klir	Square	e DRIL	R BA	Ito. M	121237
	Sta Regista		· ·	AR 0 8 20		U S	A	W	-				

		1	For State Registrar	State of M	arylan		artment of H		ınd Ment		iene 0 0	5	07647
			Decedent's Name (First, Middle	e, Last)						ate of Deat	h	Year	3. Time of Death
	Physicia		Ruth Hitchcoc	k					1	bruar		005	12:45 PM
	/Medic Examin	~	4a. Facility Name (If not institution	n, give street and numbe	r)		4b. City, Town, or	r Location of	f Death		4c. County o	f Death	
			Wilson Health	Care Cente	r		Gaither	sburg			Montg	gome	ry
	Funeral		5. Social Security Number	6. Sex 7. / 1 ☐ M 2 🛣 F	Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. D. (A	ate of Birth Month, Day,	Year)	9. Birthp Cour	place (State or Foreign ntry)
	Director		712-18-5179	ILIM ZIALF	97	Yrs.			Ju	ıly 26,	1907	0	hio
	pur *	-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City	/, Town or Lo	ocation					1	0d. Inside City Limits
	anylisho	5				1	1						1 ☐ Yes 2 🛣 No
	28a-1	Director	Maryland Mont 10e. Street and Number	gomery	Ga	ithers	10f. Zip Code			11	0g. Citizen of Wi	hat Cour	ntry?
	with sa or						20877				United S	Stat	0.5
	ns 23	era	201 Russell Av	12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of H	lispanic Orig	gin? (Specify)	res or No-	14. Race	- Americ	can Indian,
"	ritar iner	Funeral	1 ☑ Never Married 2 ☐ Mar	ried Armed Force			If Yes, specify Cuba		, Puerto Rican	1, etc.)		, White,	etc.
ဗ္ဗ	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examiner must be muilited at	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2 🔯 No	Specify:			Specify:	Wh	nite
Maryland 21215-0036	hin 72 hours after death with the Marylan a. Medical Examiner mast be notified at	Completed	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usual Occup	ation during most	t of working		16b. Kind of Bus	iness/in	dustry
7	불 등 물	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	lite.	DO NOT use retired	d)		1.	. 1 1		
7	be filed with tal Hygiene. d other than evant, the N	Co	12			A	ccounting				Federal		ernment
<u>n</u>	tal H d oth	Be	17. Father's Name (First, Middle,								Maiden Sumame	"	
<u>×</u>		၉	Alvin Jesse Hi		•	401 14 18			ie Len			Yanan 75-	Code)
Jar	3 C 8 3		19a. Informant's Name/Relation				ng Address (Street						
	s 1 and 2 if Health item 27 other tra		Judith Hollomo	n/ Niece	20b. P		S. Columbs	us St.	, Alexa		l , V1r 11 20c. Location - C		
0	ges H of t		1 ☑ Burial 2 ☐ Cremation		te c	emetery, cre. Par	matory or other plac klawn	ce)	March 2005	11.			
ţ	nit. Pagartmen ortant: injury		'4 □ Donation 5 □ Other (Me	emoria	1 Park						Maryland
Baltimore,	permit. Pages. Department of H Important: If ite any injury or of		21. Signature of Funeral Service	2	M0140	05 R	<u>ockville,</u>	Mary	land 2	0850		ry X	neral Home/ venue
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	r complications that caust only one cause on each	sed the death	h. Do not en	ter the mode of dyir	ng, such as	cardiac or res	piratory arre	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition			Sept	icemia						Onset and Death 3 Weeks
	/Medical		resulting in death)	Due to (or	as a conseq	-							
	Examiner		Sequentially list conditions,	b			rene Left	Foot				_	
-	p #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseq	10 Au							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (er	as a conseq		rial Vasc	ular	Occlus:	ion			
,092	be executed sician and burial-transit	E	1555 All I State of the State o	Due to (or	as a conseq	derice or).							
87	2 2 2	dical		d									
x 68	ertific ding p	Me	IF FEMALE:	23c. If yes, outcome	ne of pregna	ancy					22d Date	of dollar	0.01
Box	The law requires that the death certifical ate has been signed by the attending phopage 2 should be detached for use as the	by Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	1⊟Live birth 4⊟Pregnan	2 Feta	I death 3	□Ectopic pregnancy □ Other (specify) _	У			23d. Date Mon		Day Year
	the de	ysic	1 □ Yes 2 🛣 No 9 □ Unknown	9□ Unknow		eath St					1		
P.0	res that the death	h h	Part II. Other significant condit	ions contributing to deat	h but not res	ulting in the t	ınderlying cause gıv	en in Part I.	.	23e. Did tol	oacco use contri	bute to t	he cause of death?
ds,	sign d be	d b	Congestive Hea	rt Failure,	Hypo	thyroi	disn, Aor	tic		1 🗆 Ye	es 21K No	3 🗌 Prot	pably 4 Dunknown
Records,	w requir been si should	Completed				•				24a. Was a	n 24b. W	/ere auto	opsy findings available
Rec	has ge 2	m d	Stenosis, Caro	:Inoma of Gu	111					autops perforr	ned? pr	rior to co eath?	impletion of cause of
<u>a</u>			OS Mas area referred to madio	el .				OC Place	of Death (Ch	1 ☐ Yes		∐ Yes	2 No
Vital		Be c	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ationt 2	EP/Outpatio	nt 3□ DOA Oth				ence 6 🗆 Othe	r (Snacii	64)
of	F F E	To To	27. Manner of Death	28a. Date of (Month,		28b. Time o					ow injury occurre		, , , , , , , , , , , , , , , , , , ,
Division	Attanding Phr r death. actor: After thi by the funeral	tior	1 ☑Natural 5 ☐ Pend 2 ☐ Accident inves	ing (Month, tigation	Day Year)	Injury		rk?]Yes 2.∏.l	No				
<u> S</u>	or Attandii after death. Diractor: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could	: Z00, Flace UI	Injury - At h	ome, farm, st	reet, factory, office					r or Run	al Route Number,
Ó	P # # c	Certification:	4 Homicide	building	etc. (Specif	<i>'</i> y)			,	City or Town	r, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 ☑ Certify (Check only 2 ☐ Medica	ing Physician: To the be at Examiner: On the basi and manner	s of examina	owledge, dea ation and/or in	th occurred at the ti	me, date an opinion, dea	nd place, and cath occurred at	due to the c t the time, d	ause(s) and mar ate and place, a	nner as s nd due t	stated. o the cause(s)
	o tha ithin (o tha mple	Mec	29b. Signature and title of certif			1.0	29c. Licens	se number		2	9d. Date signed	(Month,	Day, Year)
	F 3 F 8		M. R.he		11.		Ind DOLL	115			Felere.	4.1.	127.2000
	h		30. Name and address of perso				Print) DO41	115				1	127,2005
	13					1		0-4	thorat	uro	Marrilan	1 20	Q77
	64	ate	Robert H. Birs	c) 20 Pag	ietrar'e Siane	ature a		. Gal	thersb	nrg.	naryrano	1 , ZU:	0.1.1
	Regist		MAR 0 8		J. J.	A STATE OF THE PARTY OF THE PAR							
			MAN	To the state of th		-/							

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health a 1 - State Registrer State of Maryland / Department of Health a Certificate of Death		giene 2 0	05 07648
	g Dharainia		Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physicia /Medic		Lorine V. Haines	MAR		505 3:17PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location Rayda 115+0 w	AA ()	4c. County o	More
	Funeral Director		5. Social Security Number 212-10-3080 6. Sex 1 Months Days Hours	Min. 8. Date of Bir (Month, Da April 0	th ay, Year) 4.1910	9. Birthplace (State or Foreign Country) Maryland
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			
	death with the Maryland ims 23a or 28a-f show rmust be rediffed at	ō	MD Baltimore Woodlawn			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	r 28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	nat Country?
	th with		2211 Southland Road 21207		United St	tates of Americ
	tams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexican	rigin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Race Black	- American Indian, , White, etc.
20	urs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XX No If Yes, Give 1 ☐ Yes 2 XX No If Yes, Give 1 ☐ Yes 2 XX No Specify:	:	Specify:	White
2-003c	72 hor	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during mos	st of working	16b. Kind of Bus	iness/Industry
V	within ane. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst		State 0:	f Maryland
D .	Hygie othar ent, II	a)	12 0 17. Father's Name (First, Middle, Last) 18. Moth	er's Name (First, Middle	, Maiden Sumame)
/land	2 should be filled within 72 hours after death with the Marylan and Menhal Hygeine. I and Menhal Hygeine is marked other than "natural, or thams 23a or 28a-f show aumatic event, the Medical Examinational Lectional at	To B		rie Gabe		
Mar	12 sho h and 7 Is mu irauma		19a. Informant's Name/Relationship (Type, Print) Mr. George Lee (Per Rep) 780 Four Seasons			
a,	Healt Healt tam 2		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		ity or Town, State
OE	Pages nent of int: If i		1 Removal from State 1 Donation 5 Other (Specify) 1 Removal from State 1 Corraine Park Cemetery	03/04/05	Woodlaw	n, Maryland
Бант	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Itam 27 Is marked any injury or other traumatic es ORGS.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rose 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rose 22. Name and Address of Facility Rose 23. Name and Address of Facility Rose 23. Name and Address of Facility Rose 24. Name and Address of Facility Rose 25. Name and Address of	iv Loring By		
			23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition A + + + + + + + + + + + + + + + + + +			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b			
_	cuted	Examlner	that initiated events c.			
ρΩ,	cate be executed bhysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
08/PN		edical	d			
ŏ	death certificate be executed e attending physician and id for use as the burial-transli	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			of delivery
D		Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Other (specify)		Mont	h Day Year
ν, T	requires that the een signed by th hould be detache	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	l. 23e. Did t	obacco use contrib	oute to the cause of death?
cords	require een sig	ted	Congestive heart tailure	10		Probably 4 Unknown
Lec	sician: The law certificate has b lirector, page 2 sl	Completed	vastric ulcers	24a. Was autop	osy pri	ere autopsy findings available or to completion of cause of ath?
NI Call	an: The	င္ပ	25. Was case referred to medical 26. Place	1 ☐ Yes e of Death (Check only o	2 INO 1	Yes 2 No
-	Physician: this certific ral director,	To B	examiner?	ursing Home 5 🗀 Resid		(Specify)
n or	ing Pł		27. Manney T Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		how injury occurred	
UIVISION	Attand death ctor: , y the f	ficat	2 Accident investigation M 1 Yes 2 Suicide 6 Could not be determined entermined 1. Place of Injury - At home, farm, street, factory, office		Street and Number	or Rural Route Number,
2	s after al Dira	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tou	wn, State)	
	To the Hospitel or Attanding Physician: The Manual Stee deal of the Transal Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date an and manner stated. Check only one)	nd place, and due to the ath occurred at the time,	cause(s) and mand date and place, an	ner as stated. d due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
	Ý		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		3/02/20	005
	Υ\		Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall	Randallst	own. MD	21133
: 1	Sta		31. Date filed (Month Day, Year) 32 Registrar's Signature		,	
	Registr	ar	Marke to Marke			

State of Maryland / Department of Health and Mental Hygiene 1 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2005 **Physician** Year March 5, ALT DORIS HEAVER 8:50P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 511 Brightwood Club Drive Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. October 19, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 84 Yrs. Maryland Director 212-12-7308 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Machical Experiment to matter in tilling a 1 ☐ Yes 2XXVo Director Maryland Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 511 Brightwood Club Lane 21093 USA filed within 72 hours after death Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S.
Arroed Forces?
12. Wes 2 □ No WW I I
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Army Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be and Mental Alt Annie Estella Andrew George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sh nent of Health and ent: If item 27 Is n Son 11215 Old Hopkins Road Clarksville Maryland21029 Allan B Heaver 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Importent: If its any injury or o XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gar. 3/9/05 Lutherville, Maryland ☐Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNA /Medical Due to (or as a consequence of): Examiner OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? by 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicido within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25743 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Kimmel MD 6569 North Charles Street 21204 Towson MD 31. Date filed (Month, Day, Year) gistrar's Signatur 32. State 8 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 935 **Physician** epruary 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death Examiner 7. Age (In yrs. last birthday) timore Greneral If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🕱 F north 217-22-6850 Director arolina Usual Residence of Decedent 10a State 10c City Town or Location 10h County 10d. Inside City Limits 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 □ No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 items 23g 8. ummin by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 V Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🔁 No Specify: Black Specify 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be ျှ Saunders Ham avence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balton Michaes f Health item 27 amtin 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State pernit. Pages 1 Dep rtment of H Important: If ite any injury or ot 1

Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Cem 2005 22. Name and Address of Facility
Carlor Colon
1701 Mc Culloh 21. Signature of Funeral Service Licenses ODC. 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Overwhelming Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical on Hemodalysis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit neral Due to (or as a consequence of) Box 68760, physician Completed by Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 99 Diaber 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s certificate has autopsy performed? 2 No 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient

28a. Dite of Injury
(Month, Day Year)

28b. Time of Injury 1 ☐ Yes 2 No Other: ٩ 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death Certification: 28d. Describe how injury occurred After **Division** or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 🗌 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai completely (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

11. D.C

Year)

0

Registrar's Signature

(Type, Print)

1215-0036	
Maryland 2	
Baltimore,	

Please T	ype or Print in Black	Indelible Ink. Ensure A	II Copies	Are Le	gible.	
For		epartment of Health and N	lental Hyg	jiene)	05 0	17
For State Registrar	(Certificate of Death	F	leg. No.		
1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day	Year	3. Tin
Cheryl	Denise	Johnson-Lewis	2	26	05	1.
4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Death		4c. Cou	unty of Death	

Months

10f. Zip Code

BALTIMORE If Under 1 Year If Under 24 Hrs.

21234

Hours

Days

8. Date of Birth (Month, Day, Year) 12 08 58

10g. Citizen of What Country? U.S.A.

e of Death 38 AM

Birthplace (State or Foreign Country)
 MD

Black

21215

Day

26

BALTIMORE MD21239

05

Year

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 Yes 2000

Physician /Medical Examiner	
Funeral Director	

Director

10a. State

GOOD

5. Social Security Number

10e. Street and Number

217-76-8748 Usual Residence of Decedent

ll Terron Ct.

SAMARITAN

Baltimore

10b. County

6. Sex

1 ☐ M 2 🖔 F

HOSPITAL

46

7. Age (In yrs. last birthday)

10c. City, Town or Location

Parkville

or iteme 23a or 28e-f show

filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28e-1 show any injury or other treumatic event. It a Medical Examinat must be notified at

as the burial-transit The law requires that the death certificate be executed Box 68760 esn detached for P.O. Records, page 2

To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: A completely filled in by the fi

Be ျှ Examine Completed by Physician/Medical Be Certification: To Medical

/Medical

Physician Examiner

Division of Vital

Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed ADivorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Social Service Administration Clerk 12th grade 4 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julia Elizabeth LeVere Eugene Franklin Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coshauna Lewis-Daughter Terron Ct., Parkville, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 3/5/05 Dulaney Valley, Dulaney Valley 21. Si nature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): IRACT INFEE RINARY Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Mo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DESCMINATED 1 🗌 Yes 2 □N6 3 □ Probably 4 □Unknown INTRAVASCULAR QUADRIPARESIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **N**o 1 atient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES MD 000

5601 ZEEBA LOCH RAVEN BLVD, 32. Registrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

			1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of Health and M rtificate of Death		iene 005	07652
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physici: /Medic		MATTIE ELIZABETH JACKSON		FEB	25 2005	8:30 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			1510 WINFORD ROAD	BALTIMORE		N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Count	**
	Director		Usual Residence of Decedent		06/23/	1910 MARY	LAND
	rland row		10a. State 10b. County 10c. City, Town or Lo	ocation		10	d. Inside City Limits
	Man a-f sh	tor	MD N/A BAL	TIMORE			¹∰Yes 2□No
	th the	Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Count	ry?
	23a		1510 WINFORD ROAD	21239		USA	
	er des tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show Ite Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes XXNo Specify:		Specify: BLA	CK
21215-003	tura cal E	pa	A 15 Decedent's Education 16a Dece	dent's Usual Occupation		16b. Kind of Business/Indi	ustry
75	in 72 m" ni Medi	plet	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ing		
21	od with	Completed		MESTIC WORKER		DOMESTIC	
2	oe filed tal Hygid d othar evant, L	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name			
yla	should be t and Mental I s markad o umatic eva	2	CHARLES GREEN	ROSA	WILLI		
			1	ng Address (Street and Number or Rura			
	1 and 3 Health tam 27 othar tr		20a Method of Disposition 20b. Place of Dispo	510 WINFORD RD,	-	MORE, MD Z 20c. Location - City or Tov	
jo	Pages nent of 1 int: If Its iry or o		ty□ Burial 2 □ Cremation 3 □ Removal from State cometery, cree	matory or other place) N CEMETERY 03/0		BALTIMORE	
Baltimore,	그 된 원 중 .		(-),				
Ba	Deparent Impo			600 LIBERTY HGH		UNERAL HOM	
	- 1		23a. Park Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	est.	Approximate Interval Between
	Physician		Immedia ause (Final diseas or condition				Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	i			
80	Examiner		Sequentially list conditions b.	ipidemi4			
_	D is	iner	Sequentially list conditions, if any, leading to immediate ausse. Lines underlying Cause (Disease or injury				
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
8760,	rate be executed obysician and the burial-transit	alE					
	ficate physis the	Physician/Medical	d				
Вох	death certifica e attending ph id for use as th	N/W	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 [23d. Date of deliver	у
Ď.	0 0 2	Icla	in the past 12 months?	_Ectopic pregnancy _ Other (specify)		Month [Day Year
P.0	at the d by the stached	hys	9 LJ Unknown		-		
S,	se ub eq	by F	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		pacco use contribute to the	i .
ord	w requir been si should	ted			1 ∐.Ye	es 2 □ No 3 □ Proba	bly 4 Winknown
Vital Records,	has by	Completed			24a. Was ar autops	v prior to com	sy findings available pletion of cause of
E H	Th ate pag	S			perform		≥[TNo
Zite Zite	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Deati	11		
ot	유무등	To	1 Yes 2 No 1 Inpatient 2 ER/Outpatiel 27. Manner of Sath 28a. Date of Injury 28b. Time of	A A Nursing Ho	^	ence 6 Other (Specify) ow injury occurred	
o	ding h. After funer	tlon	1 Natural 5 □ Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	115000	,	
Division	or Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	reet, factory, office		reet and Number or Rural	Route Number,
=	al or A s after al Dire	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town	, State/	
	To the Hospital or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funar	edical (29a. Certifier (Check only Medical Examiner: On the basis of examination and/or in				
	tha hin 24 the F	Medi	one) and manner stated.	29c. License number		9d. Date signed (Month, D	
1	To To	-	29b. Signature and title of certifier	D 2430	3	3/2/05	-// / 00//
7	/		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print		1 / -	
	5		Dr. M. Luhar MD.	3509 Easteri	7 Ave	Balto- N	ID 21224
	Sta	ite	31. Date filed (Month, Day, Year) 32. Pugistrar's Signature	Carlo			
	Regist	rar	MAR 0 8 2005	Sector Section 1			

		-	For State Registrer	State of	Marylan		artment rtificate				lental Hy	giene Reg. No.	000	15	07653
	o Di-		1. Decedent's Name (First, Middle	, Last)				_			2. Date of Do	eath Day	,	Year	3. Time of Death
	Physicia /Medic	al .	Nancy Patrici								March	2,	2005		12:55 A™
1	Examin		4a. Facility Name (If not institution						Location o	of Death			•	of Death	
			Montgomery Hos 5. Social Security Number		y House 7. Age (In yrs.		If Under		ille If Under	24 Hrs.	8. Date of Bi		lont	gome	Ly lace (State or Foreign
п	Funeral Director		215-46-0138	1 ☐ M 212 F	58	Yrs.		Days	Hours	Min.	(Month. D	ay, Year) 28, 19	147	Coun	nington, D.C.
			Usual Residence of Decedent								Juli -			Wabi	ingeon, Dio
	show ed at		10a. State 10b. County			y, Town or Lo								1	Od. Inside City Limits
	Ba-f s	cto	Maryland Montg	omery	R	Rockvil									1X Yes 2 ☐ No
	ith the	Dire	10e. Street and Number		u -		10f. Zip (- 0			_		Vhat Cour	•
	s 23e	E .	10022 Vanderbil			6 40		2085		ain? (Co.	naifu Van os N			State	an Indian,
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Medical Examinating that be notified at Once.	Funeral Director	11. Marital Status 1 Never Married 2 Marri	12. Was Dece Armed For 1 Tyes	ces?	.5. 13.	If Yes, speci	ify Cuba	in, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	0-		k, White,	
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):									
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Division	or At after d Direct in by	Certification;	4 Homicide determ	ined 286. Place	of Injury - At h ng, etc. <i>(Speci</i> i	ome, tarm, st	reet, factory,	, office			City or To	wn, State)	ar or mura	d Route Number,
	spital ours seraf filled		29a. Certifier 1☑ Certifyin	g Physician: To the	best of my kno	owledge, deat	h occurred a	at the tin	ne. date an	nd place.	and due to the	cause(s)	and mai	nner as si	lated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		Examiner: On the ba and mann	isis of examina										
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	13		30. Name and address of person												
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	y Sta	ate rar .	MAR 0		Aur J		and a								

amend item/2, 28f, perff., 341,3/1/05 TI State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Mar Physician 8:12P M Joseph Michael Jenkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Street Brooklyn
If Under 1 Year If Under 24 Hrs. Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **XX**M 2□ F 25 Yrs 10/1/1979 **Director** 212-94-7399 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Director MD Anne Arundel Brooklyn 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 431 Prince Street 21225 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: XXVever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 11 Welder Welding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Hawk Jacqueline M. Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1462 Pleasantville Dr, Ms. Jacqueline M. Jenkins / mother Glen Burnie, MD 21061 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 3/7/2005 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. ark MO1357 1 Second Ave SW, Vancura Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gunshot wound to head **Physician** Seconds /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner -transit Due to (or as a consequence of): burialattending physician Box 68760 cal the Physician/Medi as IF FEMALE: nse i 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending self inflicted gunshot to head 8:12 PM Mar 4105 1 ☐ Yes 2 ☐ Mo 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Numb City or Prince) 2-122 431 Front St. Brackly N.W.D. (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide home - bedroom 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and tille of certifi 29d. Date signed (Month, Day, Year) ME 31473 Mar 5, 2005 MO 1 at 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemlock Cone Way Ellicott City Mb 21042 PATRICE A. TOYE, MO 4565 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHARLOTTE MARCH VIOZANO 2005 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Days 1 M 2 V Director 214-54-7773 May 15, 1949 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10h Counts 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Items 23a or 28e-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Ellicott City Directo Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21043 3609 Mt. Ida Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marijal Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ Specify. 3 Widowed 4 Divorced "natural", leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Custodial Compl Elementary/Secondary (0-12) College (1-4or 5+) **Custodial Service** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Eva Virginia Cross ဥ William Wesley Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importent: If item 27 Is: any injury or other treun 3609 Mt. Ida Drive Ellicott City, Maryland 21043 Mr. Mark Thomas 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 03/12/2005 Ellicott City, MD * 4 □Donation 5 □ Other (Specify) St. John's Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) and Death **Physician** homo tcute Myocar DITC /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: 1 ☐ Yes 2 ☐No Other: 일 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending

Division of Vital Records, P.O. Box 68760. After To the Funerel

> State Registrar

11055 Little PATUXENT Columbia MA M. M. FLOWIERS
31. Date filed (Month, Day, Year) 22. Reg 22. Registrar's Signature

and manner stated

investigation

6 Could not be determined

3 Suicide

29a. Certifier

4 - Homicide

29b. Signature and title of certifier

ted cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D20789

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item/10e, perFH, G842, 4/8/05 TT Amend item 19a per inf 9843 5-5-05 vt

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Examin Funeral Director		4a. Facility Name (If not institution, GOOD SAMARITAN] 5. Social Security Number 215-94-4232 Usual Residence of Decedent	HOSPITAL	(In yrs. last birthday,		PRE CITY If Under 24 His Hours Mis	S. 8. Date of B		NA 9. Birthp	lace (State or Fo itry) MCl .
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3e or 28a	Funeral Director	10e. Street and Number 3308 Westover	8 Westerwald	Avenue	10f. Zip Code 21	218	2.2.		izen of What Cour USA	itry?
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State of Maniford / Department of Hos	olth and Mantal Hugiana

		For	State of Marylan	-		of Heal		Mental Hy	giene	2005	07657
		Registrar 1. Decedent's Name (First, Middle, Last)		Ce	runcate	e of Dea	un	2. Date of De	Reg. No.		3. Time of Death
Physicia	ın		-					Month MARIA	Day 5	Year	06:50 AM
/Medic		Felix 4e. Facility Name (If not institution, give st	C.	Kasul		own, or Local	tion of Death	Titulian	-	County of Deeth	06.304
Examin	er	NIOTTE ARUND		177		- Bur			An	ne Are	un201
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year If U	nder 24 Hrs.	8. Date of Bird (Month, Da	h		place (State or Foreign
Director		110-26-7647	M 2□ F 73	Yrs.	Months	Days Ho	urs Miri.	Dec. 4			nsylvania
pur 🛦		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Le	ocation						10d. Inside City Limits
sho	20	North									1 ☐ Yes 2 No
28a-1	Director	Carolina Craven 10e. Street and Number	Hav	zelock	10f. Zip	Code			10a. Citiz	zen of What Cou	ntry?
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death ms 2	Funeral		2. Was Decedent Ever in U	l.S. 13.	Was Deced	ent of Hispani	c Origin? (Sp	ecity Yes or No	- 1	4. Race - Ameri	can Indian,
after or its		1 Never Married 2 Married	Armed Forces? 1 MYes 2 □ No If Yes, Give	-	1 ☐ Yes 2	fy Cuban, Me	xican, Puenc ecify:	Hican, etc.)		Black, White, Specify:	etc.
be filed within 72 hours after death with the Maryland lat Hygiene. In thygiene then "netural", or items 23a or 28a-f show event, the Madical Exameter must be could be a second at the Madical Exameter must be could be a	d by	3 Widowed 4 □ Divorced	Year or Dates:				y.			W	hite
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filed Hygin other ent, I	C	17. Father's Name (First, Middle, Last)	IV'A	PIOU	JCC1OI			e (First, Middle,			rer
id be ked c	To Be	Kazimir		Kasu]	len	м	arv				Randis
should and Mer marke umatic		19a. Informant's Name/Relationship (Typ	e, Print)					al Route Numbe	er, City or	Town, State, Zij	
and 2 ealth a n 27 is		Mark Kasulen (Son)	P.O.	Box 1	3 Glen	Ellen	, Calif	ornia	a 95442	
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		Place of Dispo cemetery, cre-	osition (Nam matory or ot	e of her place)	1	Date	20c. Loc	cation - City or To	own, State
Pages ment of I ant: If it		*4 □ Donation 5 □ Other (Specify)		view (Cremat	ory	3/9/	05	Balt	timore,	Marylano
permit. Departr Imports any inju		21. Signature of Funeral Service Licenses	2	/ / 2 N	2. Name and McCull	Address of F y-Poly	niak F	uneral	Home	, P.A.	5.00-0.0 4 .00-0.00
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The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	y Ph	Part II. Dther significant conditions cont	nbuting to death but not res	utting in the u	inderlying ca	use given in F	Part I.	23e. Did to	obacco us	se contribute to t	he cause of death?
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Attending Physician: r death. ector: After this cartification in the funeral director.	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗌 Yes	2 No				
or At after d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti fy)	reet, factory	office		City or Tox		f Number or Rura	al Route Number,
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medical Examine one)	er: On the basis of examina and manner stated.	ation and/or in	vestigation,	in my opinion,	, death occur	red at the time,	date and	place, and due to	the cause(s)
To the Mithin To the Somple	Me	29b. Signature and title of certifier			29c.	License num	ber		29d. Date	signed (Month,	Day, Year)
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U			-RANCIS MI	7770	PITA	DE	GLE	21 (32) (3)	11/2)	1110	21061
Sta Registra	-	31. Date filed (Month, Day, Year)	32. Regularar's Signa		Rocall	8 .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Year Physician MARCH PENELOPE CARPENTER KIESELBACH 2:45 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GLEN MEADOWS GLEN ARM BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/29/1920 Birthplace (State or Foreign Country)
 NEW YORK 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F 081-20-2128 84 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE GLEN ARM 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11630 GLEN ARM ROAD 21057 APT. USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 □ Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HENDERSON HIGH 4+ YEARS Elementary/Secondary (0-12) SCHOOL TEACHER parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is markad othe ery linity or other treumatic event, 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN T. CARPENTER RUTH GARDINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UPPER BLACK EDDY, PA 344 MARIENSTEIN RD. 18972 PETER KIESELBACH/SON 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State METRO CREMATORY, INC. 3/8/2005 * 4 □Donation 5 □ Other (Specify) CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Physician VNa mentho /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospitel or Attending Physician: The law requires that the death certificate be exacuted physician ar s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? certificate 1 🗆 Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 🗌 Inpatient P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After t 5 Pending 1 Natural Injury 1 Yes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 25201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 . Charles St. Bolts. Md

State Registrar

31. Date filed (Month, Day, Year) MAR 0 8 2005 egistrar's Signature

6701

BMC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Yeer **Physician** Ethe 12:05 am 2005 March /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Keswick MultiCare Center Baltimore N/A If Under 1 Year 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (Stete or Foreign Country) **Funeral** 1□M 2K□ F Months Days Hours Min 96 212-07-2591 Yrs. Director April 30,1908 Maryland Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, the Medical Exerciner must be routlised at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 √ Xes 2 □ No Funeral Director 10e. Street and Number Keswick MultiCare Center 10f. Zip Code 10g. Citizen of What Country? 21211 USA 700 W. 40th Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Be Completed by Specify ¥⊠ Widowed 4 □ Divorced white 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Floor Supervisor Knothe- Manufacturing 8th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Pearce Mary Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary A. Smith Niece 3502 Thomas Point Ct. 2B Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XIX Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/3/05 Hampden, Maryland 22 Name and Address of Facility Burver—Henss—Seitz Funeral Hone, Inc. 3031 Falls Road baltimore, MD 21211 neral Service/Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one jause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical anemia Examiner Due to (or as a consequence of) Physician/Medical Examiner 9 ASTroinTESTINA) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attanding Physician: The law requires thet the death certificate be exacu Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ementia Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy hypertension page 2 s TOTAS 21-No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: Certification: To 1 ☐ Yes 2 ☐ No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu I Director: A 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edical 29a. Certifier to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Um mo 35102 2005 march 2 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) ROAD BALTIMORE MARY AND 104 Tunbridg m.D Hilar DON

Registrar **DHMH 16 Rev 6/95**

State

32. Restrar's Signature

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	1 - For State Registrar	State of Maryland	d / Department of He Certificate of D		ygiene 005 07660
Physician /Medical				2. Date of I Month	Death Day Year 12:37 PM
Examiner Funeral	4a. Facility Name (If not institution, give Sacred Head 5 Social Security Number 6 Second Security Number 6 Second Security Number	rt Hospita	st birthday) If Under 1 Year	erland	4c. County of Death Allegany 9. Birthplace (State or Foreign
Director	236-58-0804 Usual Residence of Decedent	M 2∰F 91	Yrs. Months Days	Hours Min. Sept.	Jay. Year 13 West Virginia
Marylani II show	toa. State 10b. County West Virginia Mineral	10c. City,	Town or Location Keyser		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Mar 3e or 28e-f si	10e. Street and Number RR 4 Box 184		10f. Zip Code 26726		10g. Citizen of What Country?
Itied within 72 hours after death with the Maryland Hygiene. Thysiene. The Medical Examination in the notified at the Medical Examination in the Medical Examination in the Completed by Funeral Director.		12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban,	panic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)	Black, White, etc.
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i, INICAL YICA and 2 should is salth and Men or 27 is marke ier traumatic.	19a. Informant's Name/Relationship (T) Dorothy J. Clark -		19b. Mailing Address (Street and RR 4 Box 184, I		nber, City or Town, State, Zip Code) irginia 26726
of He of He of He	20a. Method of Disposition 1 Burial 2 Cremation 3 F		ace of Disposition (Name of metery, crematory or other place)	Date	20c. Location - City or Town, State
permit. Pag Department Important: It any injury o	*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		ostead Cemetery	of Facility Chanel P	Α.
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	ence of): Pry Arteny ence/of):	lial Infar	tion Hours
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nysician: Th nis certificate I director, pag To Be Col		lospital: 1 ☐ Inpatient 2 🔀	P/Outpatient 3 DOA Cther	26. Place of Death (Check only	y one) sidence 6 □Other (Specify)
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he Hospital or n 24 hours afte he Funeral Dis oletely filled in edical Cert		sician: To the best of my know ner: On the basis of examinational manner stated.	rledge, death occurred at the time on and/or investigation, in my opin	, date and place, and due to the nion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the within 2 To the complet			29c. License		29d. Date signed (Month, Day, Year) 3 4 0 5
i	30. Name and address of person who co	empleted cause of death (Item :	23a) (Type, Print)	1244	W/T/03
State Registrar		2. Registrar's Signatu	TOST DOTY ME	V 031229	

		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	nth Dav	Year 3. Time of Dear
Physic /Medi		Willi	arm P.	Krepp	el		MARCH 4	i, [©] 2005	10:19 A
Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County	of Death
		3209 POLAR AVE			HALETHO				MORE CO
Funeral Director		216-68-9427	5. Sex 7. Age (In yr. 49	s. last birthday; Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date) Oct. 22	1956	9. Birthplace (State or For Country) Maryland
and w	1	Usual Residence of Decedent 10a, State 10b, County	10c. (City, Town or L	ocation				10d. Inside City Lin
Maryl f sho	ō	M1 D-1+4	wasa 11.	.] . + b . v	20				1 ☐ Yes 2X
the 28a-	rect	Maryland Balti 10e. Street and Number	more H	alethor	10f. Zip Code			10g. Citizen of W	/hat Country?
death with the Maryland ms 23a or 28a-f show result be notified at	Funeral Director	3209 Polar	Ave			227		USA	·
ms 2	lera	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No		- American Indian,
after or ite	F	1 Never Married 2 Married	Armed Forces?				Hican, etc.))	k, White, etc.
ours a	i by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2火 No	Specify:		Specify.	:white
72 ho	Completed by	15. Decedent's (Specify only highest	s Education grade completed)	(Give	edent's Usual Occup	during most of work	ing	16b. Kind of Bu	siness/Industry
ithin nan "	npi du	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired	1)		A 4	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Unportant: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Examiner must be notified at any Injury or other traumatic event, the Modeal Examiner must be notified at appear.	Be	17. Father's Name (First, Middle, L		001	Cn	18. Mother's Name	,	маюн эйтат	⊕ Gaitley
ould Men Parka	2	William	Krep	10000	Sr.	Kathl			
and raun		19a. Informant's Name/Relationsh Kim Schroyer	sister		ing Address (Street: 306 Spruc				
f and lealth im 27		20a. Method of Disposition		E-consequence and a second			Date		City or Town, State
H of H		1 Burial 2 Cremation			osition (Name of omatory or other place				
tmen tant		'4 □ Donation 5 □ Other (Sp			ematory I		:005	Baltimor	re Maryland
permil Depar Impoi any Ir		21. Signature of Freneral Service L	iceocra / / L MI	· /)2	2. Name and Addre	Sta			Home P.A.
Examiner		Sequentially list conditions,	b						
te be executed ysician and ne burial-transit	cai Examiner	Sequentially list conditions, if any to amount of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons						
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	g		Registrar 1. Decedent's Name (First, Middle, Li	ist)		061	incate of t	Dealli	2. Date of D				3. Time of Death
	Physicia /Medic		Donald Raymond 1	Little, Jr	•				Month Marc	h 4,	2005	∕ear	0400 A. M
	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or				4c. County of	Death	
	7		Northbound Route				Silver If Under 1 Year	Spring If Under 24 Hrs					y County
	Funeral Director			Sex 7. Ag 1 ☑ M 2 □ F 3.	ge (In yrs. Iasi 8	Yrs.	Months Days	Hours Min.		ay, Yea 19 1			lace (State or Foreign try) land
	pu ,		Usual Residence of Decedent		10-07-7				TIPLII				
	faryla	ō	10a. State 10b. County Maryland Baltim	nre	10c. City, T		thwood					11	0d. Inside City Limits 1 ☐ Yes 2 No
	the N	Director	10e. Street and Number	<u> </u>		1101	10f. Zip Code			10g. (Citizen of Wh	nat Coun	try?
	h with	a O	6923A Lachlan Cir	ccle			2123	39			USA		•
	ems S	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S	pecify Yes or N	10-	14. Race	- America White, e	
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Ptyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28a-f show eny injury or other treumetic event, I'm Medical End. In at must be rediffied at once.	þ	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1	☐ Yes 212 No	Specify:	,		Specify:	Wh	ite
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P	al Hyg	Bec	17. Father's Name (First, Middle, Las					18. Mother's Nar	•)	
V Va	ould b Ment	70	Donald Raymond L			_		Carolyn			-		
Mar	d 2 sh h and 7 is rr treurr		19a. Informant's Name/Relationship Sharon Lynn Litt				g Address <i>(Street a</i> A Lachlar						
<u> </u>	Healt Healt tem 2 other		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of		Date	-	Location - C		
Baltimore, Maryland 21215-0036	t. Pages tment of tent: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec	(ty)		y Hi	natory or other place 1 Mem. G	ardens 3,	/7/2005	Ba	ltimor	ce, l	Maryland
Bal	permi Depar Impo eny ir		21. Signature of Funeral Service Lice	insee Barren K	<i>)</i>	В	. Name and Addres ruzdzinsk	ki Funera	al Home	P.A		-1100-	success:
	DEL SE		23a. Part I. Enter the disease, or con thick, or heart failure. List only	pplications that cause	d the death.	Do not ente	$407 \Omega ld$ For the mode of dying	Pastern A g, such as cardia	AVENUE] or respiratory	ESSO arrest,	x, Md.	. 21.	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Head	and n		injurie.	5					Interval Between Onset and Death
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8760,	ate be executed hysician and the burial-transit	_	that initiated events resulting in death) Last	Due to (or as	a consequen	nce of):							
Division of Vital Records, P.O. Box 6876	To the Hospitel or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pregnancy				23d. Date Month		ry Day Year
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on of	ing Phys T. After this funeral di	lon: To	Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	y Year)	Bb. Time of Injury	28c. Injury Work	4 Li Hursing I	28d. Describe	how in	jury occurred		At scene
Divisio	or Attendater death Director:	Certification:	2月 Accident investigate 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of In	jury - At home tc. (Specify)		AM 1 1	163 2 200		(Street	and Number	Same.	Route Number,
_	To the Hospitel or Attending Physician: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis of and manner st	of my knowle	edge, death and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the	e cause	(s) and mann	ner as sta d due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier Jossfal	Ireense	eng A	LD	29c. License OCI				Date signed (Day, Year)
	10		30. Name and address of person who	completed cause of c	death Item 23	За) (Туре,	Print) 111 Pe	enn Stre	et Bal	timo	ore, Ma	ary1	and 21201
:	Sta Registr		31. Date filed (Month, Day, Year)		rar's Signature		de						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MARCH 03 2005 **Physician** LOWMAN 7:15 P ELEANOR /Medical 4c. County of Death N/A 4b. City, Town, or Location of Death BALTIMORE 4a. Fecility Name (If not institution, give street and number) Examiner 1725 HOLLINS STREET APT 2 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 201F 12-12-1936 Maryland **Director** 218-36-2663 68 Usual Residence of Decedent death with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, If a Medical Exacting the notified at 1 Yes 2 □ No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 United States 1725 Hollins Street Apt. 2 Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 years Homemaker Own Home n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Ellen William Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 114 Brickhead St. Baltimore, MD Joseph V. Smith (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 3-8-2005 Glen Burnie, MD Glen Haven Mem. Pk. 21. Sign was of Fineral Service Lines ee McCully-Polyniak Funeral Home, P.A. Fort Ave. Baltimore, MD J. Wayne Osterling Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to speath but not resulting in the underlying cause given in Part I. Records, 1 🗌 Yes 2No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 20 No 21. No 1 Yes Division of Vital director. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation To the nosperation within 24 hours after death.

To the Funerel Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

29d. Date signed (Month, Dey, Year)

AVT. BALTO. M. 21227

_			1 - For State Registrar	State of Man		artment of I tificate of			ene 005	07664
	Physici		1. Decedent's Name (First, Middle, Last Kenne th	100				2. Date of Death Month MAT	Day Year	3. Time of Death 6:36P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	al Contor	4b. City, Town, o	r Location of Deat	h	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Y 10-28-	9. Birth	place (State or Foreign intry) Md.
	Aaryland I show ed al	ō	10a. State 10b. County Md . NA	10	Oc. City, Town or Lo Balt	cation imore		-		10d. Inside City Limits Y☐ Yes 2 ☐ No
	with the A Sa or 28e-	Funeral Director	10e. Street and Number 1217 W. Fayette S	Street		10f. Zip Code 212	23	10g	. Citizen of What Cou USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-1 show any Injury or other treumetic event, the M-clical Examinar must be notified at Once.	by Funera	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
21215-0036	within 72 hou ane. than "nature he Wudical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	(Give	DO NOT use retire	during most of wor	rking 16	b. Kind of Business/li Varies	
	d be filed intal Hygie red other	Be	12th grade 17. Father's Name (First, Middle, Last)	Le		inter	18. Mother's Nar	me (First, Middle, Ma		ood
Maryland	s 1 and 2 should t Health and Me tem 27 is mark other treumeti	ဋ	David 19a. Informant's Name/Relationship (7) Agnes Lee		19b. Mailir	ng Address (Street	and Number or Ru		City or Town, State, Zi	p Code)
altimore,	Pages 1 annent of Heannert: ffitem		20a. Method of Disposition 1 Disposition 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	20b. Place of Dispo cemetery, cren Mt. Zion	natory or other pla	_{сө)} 3–8-		c. Location - City or T ansdowne ,	
Balti	permit. Departn Importe any Inju		21. Signature of Funeral Service Licens	one		Name and Addre			nore, Md. North Ave	21202 e.
	Physician /Medical Examiner	Į.	23a. Part1. Enter the disease, or complishook, or heart failure. List only of the disease or condition resulting in death) Sequentially list conditions,	ne cause on each line.	pscs of sequence of):	er the mode of dyi	ng, such as cardiad	c or respiratory arrest		Approximate Interval Between Onset and Death
8760,	icate be executed physician and the buriat-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause is the riving that initiated events resulting in death) Last	Due to (or as a co						
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rds, P	The law requires that ste has been signed b page 2 should be deta	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Vital Records,	10	e Completed	25. Was case referred to medical					24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
of Vii	di S	To Be	examiner?	lospital:	2 ER/Outpatien	t 3□DOA Ott	or	ath <i>Check onl. one</i> lome 5 🗌 Residend	e 6 □Other (Speci	fy)
ion o	ding After fune		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injui Wo M 1	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division	tel or Attenders after deatled Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edicai	one)	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	and place, and due t	o the cause(s)
)	To To	Σ	29b. Signature and the of certifier	MD		29c. Licens			Date signed (Month,	Day, Year) 2005
	3		30. Name and address of person who come the Northern Roman		South 6	Print) reene St	. Bati	mose, m	D	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	(Single)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 05 Physician 9130 AH unda W 0 aire 3 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Raltimore** Cockeysville MD Masonic Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1**∑**M 2□ F Vrs Director 102 MD 212-05-6571 Feb. 12 1903 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Merylend neat of Heelth and Mentle Hyglene.
Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other trannatic event, the McGoal Eur inter mat be notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD **Baltimore** Cockeysville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 300 International Circle Funeral Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: Specify: white þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Asst. Mgr.-Customer Acctg. 12 n/a Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emily E. Parks Isaac Frankin Laird 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Donald F. Laird/Son 6113 Marlora Rd., Balto., MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Important: If ite any Injury or of once. 1 Surian 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Parkville, MD Parkwood Cemetery 3/11/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Bryan W. Clary 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner to (or as a consequence of) Examine physician end s the buriel-transit or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as a consequence of): es ettending p for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 Sec 2XNo 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 40 Nursing Home 1 Yes 2 XNo ٩ 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation ours efter deeth.
nerel Director: Aft
filled in by the fur 1 ☐ Yes 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D20649 2005 d address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Chas. St., Towson, MD 21204 John W. Bowie, MD 31. Date filed (Month, Day, Year) gistrar's Signature MAR 08 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 07666

						Ce	rtifica	te of	Death		R	leg. No.	00	01000
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dee	th		3. Time of Death
	Physici	_	Dorothy Ci	laire Llo	vd						Month March	Day 4,	Year 2005	01:55PM
	/Medic Examin		4a Fecility Neme (If not institution,						4b. City, To	wn, or Lo	cation of Death	4c. County		01.33111
.	LXdIIIII	er	743 Rosewood Ro		•				Seve	rn		Anne		107
_					7. Age (In yrs.	lest birthday) If Und	er 1 Year	If Under		8. Date of Birth		9 Birthol	lace (State or Foreign
	Funeral Director		219-42-0979	1□M 2☑F		00 Yrs.	Months	Days	Hours	Min.	April 1	0.1944	MD	try)
		ł	Usuel Residence of Decedent					1			1			
	and sale	Ì	10a. Stete 10b. County		10c. Ci	ty, Town or L	ocation						10	0d. Inside City Limits
		6	MD Anne A	runde1	Sor	ern								1 □ Yes 2 1√2 No
	288	Director	10e. Street end Number	Tunder	bev	CIII	104.7	ip Code				0g. Citizen of V	What Cour	tn/2
ž	winn 72 nou's atter death with the maryland ene. Then "naturel", or Hems 23a or 28a-f show he Medical Examiner must be notified at	늄		-							'	-		пут
-	23	Funeral	743 Rosewood Roa					144				U.S.		
-		L L	11. Marital Status	12. Was Dece	ces?	J,S. 13.	Was Dec	edent of H ecify Cuba	lispanic Ori an, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
3	9 9		1 ☐ Never Married 2 ☐ Marrie	If Yes, Give	9		1 ☐ Yes	2X No	Specify:			Specify	. Whi	te
Š		db	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ites:									
ក់	nath Class	Completed	15. Decedent's (Specify only highest	Educetion grede completed)		16a. Dece	dent's Us kind of w	ual Occup	ation during mos d)	t of worki	ing	16b. Kind of Bu	usiness/Ind	lustry
v :		5	Elementary/Secondary (0-12)	College (1-	4or 5+)									
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	ital Hygi d other event, I	Be	17. Father's Neme (First, Middle, La	ast)					18. Mothe	er's Name	(First, Middle,	Maiden Surnam	10)	
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E :	should and Men marke umatic		19a. Informant's Name/Relationship	p (Type, Print)		19b. Maili	ing Addres	ss (Street	and Numbe	er or Aura	I Route Number	r, City or Town,	State, Zip	Code)
2 1	and 2 salth a n 27 is	ı	Mr William J. L1	oyd-Husba	and	743 E	Rosew	ood 1	Road	Seve	en, MD.	21144		
ָט ע	is a range and with the manyan Health and a standard mann the manyan Health and a Mental Hygiene. Health and Mental Hygiene. Hem 27 is man/ked other than "naturel", or thems 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ı	20a. Method of Disposition	•	20b. I	Place of Disp	osition (Na	ame of	201		Date	20c. Location -	City or Tox	wn, State
	y or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation / 5 ☐ Other (Spe		Gar Gar	Place of Disponentery, cre dens O	f Fa	ith M	lemori	ial, M	larch.	. 1		1) 1/1
	in train		21. Signature of neral prvice like	- 11					ss of Facilit		,2005 B	altimor	e(ove	erlea) Md.
ם ם	permit. Pages I an Department of Heal Important: If item 2 any injury or other DDC®.	J	Zir digitation di Titolgia Visco in			Sī	ngle	ton F	unera	1 Hc	me, P.A	•		
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	TIS!		23a. Puri. Enter the disease, or co	omplications that can nly one cause on ee	used the deat ech line.	th. Do not en	ter the mo	de of dyir	ng, such as	cardiac c	r respiratory arr	est,	Street Co.	Approximate tnterval Between
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	/Medical		Immediate Cause (Final disease or condition		in	2	Ca	MC	es					5 Month
٠	xaminer		resulting in deeth)	a	Due to (c	or as a conse	quence of):					- 1	
7	-	Examiner											1	
/	pu pu	E	Sequentially list conditions.	b	Due to (d	or as a conse	quence of):						
5	an an miait		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury										i	
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	entific	- □	25. Was case referred to medical examiner?					1 41		of Death	(Check only on	e)		
	l dire	၉	1 ☐ Yes 2 ☑ No		patient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4□Nu		ne 5 eside)
- 5	Ter the residence	ë	27. Manner of Deeth 1 ☑ Naturet 5 ☑ Pending	28e. Date of (Month)	f Injury n, <i>Dey Year)</i>	28b. Time o Injury	of	28c. Injur Wor	y et k?	2	28d. Describe ho	w injury occurr	ed	
	A: A	ä	2 ☐ Accident investigat				М	1 🗆	Yes 2 🗆	No				
	er de	≝	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ed 286. Place (of Injury - At h		reet, facto	ry, office		2	28f. Location (St City or Town	reet and Numb	er or Aural	Route Number,
5 3	s affine self in the self in t	Certification:		Suidi.	g, c.c. (opcon	,,					,	,,		
al con	hour y fill		29a. Certifier 1 Certifying	Physician: To the b	est of my kno	wledge, deat	h occurred	at the tin	ne, date an	d place, a	and due to the co	euse(s) and ma	nner es sta	ated.
3	within 54 hours after death. To the Funerel Director: After this certificate has been signed by the atten- completely filled in by the funeral director, page 2 should be datached for u	edicai	(Check only 2 Medical Ex	aminer: On the bas end manne	sis of exam i na er stated.	tion end/or in	vestigation	n, in my o	pinion, dea	th occurre	ed at the time, de	ate and place, a	and due to	the cause(s)
	vithir omp		29b. Signature and title of certifier				29	c. Licens	e number		2	9d. Date signed	(Month, E	Day, Year)
	> - 0		Manan	han_	a.D			D	395	05	٨	nand	h7.	2005
		-	20. Name and address of part			n 22a) /T	Dein#\				1 1	, , , , ,		2005 MD21061
	ID		30. Name and address of person wh	no completed cause		n 23a) (Type,	1 ne h	sital	10	, (·	gles 1	Sum	ie, 1	ND 21061
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	Sta	е	MAR 0 8 2	005	giotidi s Signa		1							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registramend ITEM #18 PER FH C8413/08/05 JH 5 Reg. No: 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:20 PN 2005 BENJAMIN MARCH 03 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Hospital of N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, MAR . 23, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1√M 2□F Days Hours Yrs. 578-10-8866 89 Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2526 SUMMERSON ROAD 21209 USA or itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No WHITE Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene. 7 ia markad other than "na College (1-4or 5+) Elementary/Secondary (0-12) RETAIL DEPARTMENT STORE BUYER 18. Mother's Name (First, Middle, Maiden Sumame)

ANNA ROSE BLODOTT 17. Father's Name (First, Middle, Last) Be LEVIN **ABRAHAM** ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health an.
Important: If Itam 27 Is m.
any injury or other 2526 SUMMERSON ROAD - BALTIMORE, MD 21209 SADIE LEVIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BETH HAMEDROSH HAGODOL 3/6/2005 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Septice Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Gause (Final disease or condition resulting in death) Cryptogeniz Physician /Medical Due to ras a con-**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2⊞ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred Hospital or Attanding Pl 24 hours after death. Funeral Diractor: After the 27. Mannes of Death 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital v within 24 hours at To the Funeral D 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number Mathen RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATE (EW Registrar's Si ay0 8 2005 State

DHMH 17 Rev 1/2001

Registrar

BENHAMIN

Patient

			For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of H	lealth and Death		giene) () Reg. No.	5 07668
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	3. Time of Death Year
	Physicia /Medic	al	William Fran		S			Feb.	25 20	005 1206 ^M
	Examin		4a. Fecility Name (If not institution, give st			4b. City, Town, or		ath	4c. County	
			Carroll Hospital C		Mary and the state of the state	Westm If Under 1 Year	inster	rs. 8. Date of Birt		arroll
	Funeral		5. Social Security Number 6. Sex 152	M 2 F	In yrs. last birthday) 56 Yrs.	Months Days	Hours Mi		v. Year)	9. Birthplace (State or Foreign Country) Maryland
	Director		Usual Residence of Decedent		50			reb. o	, 1747	Haryrand
	/land		10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Many -f sh	ţō	Maryland Carroll		Mt. A	lry				1 ☐ Yes 2 ⊋No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?
	th wil	alD	5690 B Demitt C	ourt		21	771		United	States
	sue sue	Funeral Director	11. Marital Status	2. Was Decedent Ev Armed Forces?	er in U.S. 13.1	Was Decedent of H	fispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race Blac	e - American Indian, k, White, etc.
98	within 72 hours after deeth with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Madical Exama harmust be notified at	by Fu	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give	1967-	1☐Yes 2XX No	Specify:		Specify	WHITE
Ö	hours turel'	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates: 1	900	dent's Usual Occup	ation		16h Kind of Bu	usiness/Industry
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7	r the	mo.	Elementary/Secondary (0-12) 8TH	College (1-4or 5+)	Plumb	er			Plumbin	Q
פ	othe vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumam	e)
Maryland	Ments Ments arked	To	Roy Clifton Mills				Violet	Virginia	Lease	
an	and and le mu		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Numbe	er, City or Town,	State, Zip Code)
2	and ieelth m 27 her tr		Barbara Mills (wife	:)	5690 20b. Place of Dispo		Ct. Mt.	Airy, MD		City or Town, State
Baltimore,	ges 1 t of H if its or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		cemetery, crer	natory or other plac			200. Lucation	City of Town, State
Ë	t. Pa rtmen rtent:		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service General		S. Carrol	.1 Cremato 2. Name and Addre		2/2005	Winfiel	.d. MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23e or 28e-f show amy injury or other treumatic event, the Medical Examination at any injury or other treumatic event, the Medical Examination at Denotified at an		21. Signature of Annual Service Liverise					eral Home	and Cr	ematory, P.A.
			23a. Part1. Enter the disease, or complic	ations that caused th	ne death. Do not ent	er the mode of dying	mitt Ct ng. such as card	 Mt. Air iac or respiratory ar 	rest, MD 2	Approximate
			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line	. ^					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		consequence of):					your 5
	Examiner		Sequentially list conditions b.							
	D =	ner	Sequentially list conditions, if any, leading to this cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consectional of:					
	and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to fee ee e						
8760,	death certificate be executed e attending physician and ind for use as the buriat-transit			Due to (or as a	consequence of):					1
	physicate s the t	dicai	d							
9 X	death certifica attending phate as to	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d. Dat	te of delivery
Вох	death a atter d for u	Physician/Med	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti		∃Ectopic pregnancy ∃ Other <i>(specify)</i>	y		Moi	nth Day Year
O.	that the died by the detached	hys	9 Unknown	9□ Unknown						
S,	es tha igned be del	by P	Part II. Other significant conditions con-	tributing to death but	not resulting in the u	nderlying cause giv	en in Part I.			ribute to the cause of death?
ord	law requires as been sign 2 should be							1 🗆 `	Yes 2□No	3 Probably 4 Mnknown
ec	lawr as be	ompleted						24a. Was autor	osv n	Were autopsy findings available prior to completion of cause of
œ	The Tate has page	Con						perfo 1 ☐ Yes		death? I ☐ Yes 2 ☐ No
Vital Records,	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		0#	105	eath (Check only o		
of	this aldii	5	Yes 2 No	1 Inpatient	2 ZER/Outpatie	II 3 DOA	4 LINUISIN	Home 5 Resident	dence 6 Dother	
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Division	I or Attending after death. Director: After din by the fune.	flca	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, st	reet, factory, office				er or Rural Route Number,
D		Certification;	4 Homicide	building, etc.	(Эрөсііу)			City or To	wii, State)	
	To the Hospitel or within 24 hours afte To the Funerel DII completely filled in	edicai (29a. Certifier 1 Certifying Phys (Check only one)		xamination and/or in					nner as stated. and due to the cause(s)
	To the	Me	29b. Signature and title of sertifier			29c. Licens	se number		29d. Date signed	d (Month, Day, Year)
	/		>11 +11-1de	7		000	25192	4	Februa	ary 26,2009
	6		30. Name and address of person who co	mpleted cause of dea		Print)	,	0 /	1 /	mp 21107
	Sta	ate	1- CIN CIT 1- Hem. 31. Date filed (Month, Day, Year)	32. Registrar	M) 297	3 Manch	lester 1	KU Manc	nester	· 111)21100
	Regist		31. Date filed (Month, Day, Year) MAR 0 8	2005	's Signature	efectes.				

			1 - For State Registrar	State of Maryla		artment of He rtificate of D	alth and M	ental Hygi	_	5 07669
	Physici		1. Decedent's Name (First, Middle, Las Werton R. McCray	1)				2. Date of Death Month	_	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	tal	4b. City, Town, or L	ocation of Death		4c. County of I	
2	Funeral Director		5. Social Security Number 6. Se 213 34 1626		last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 3,	Year) 9.	Birthplace (State or Foreign Country) est Virginia
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	he Mar 8a-f st	ector	Maryland Baltimor	e	Es	ssex	-			1 ☐ Yes 2X No
	a with t	Dir	10e. Street and Number 108 George Avenue			10f. Zip Code 21221		10	g. Citizen of Wha	t Country?
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Example mainled at once.	by Funeral Director	11. Marital Status 1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Kore	l	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc. White
0-6171	vithin 72 ho ne. han "natur is wedical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupati kind of work done du OO NOT use retired)	on ring most of working	ng	6b. Kind of Busin	
7	filed v Hygie othar t	စ	12 17. Father's Name (First, Middle, Last)	5+		Teacher	8. Mother's Name			hool System
yland	ould be Mental Brkad o	To B	Kelvin L.McCray				Estella F			
Mar	d 2 sho th and th is mu trauma		19a. Informant's Name/Relationship (7 Mary McCray (Sister	,		ng Address (Street and eorge Aver				te, Zip Code)
e e	of Health itam 27 other tr		20a. Method of Disposition	20b.		sition (Name of natory or other place)			Oc. Location - City	or Town, State
oaltimore	permit. Pages 1 a Department of Hea Important: If itam any injury or othe once.		1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Ba	yview (Crematory	3/8/2	005 B	altimore	, Maryland
מ	permit. Departr Importa any inji		21. Signatura Funeral Service Licens	ENINED.	B	Name and Address ruzdzinski 407 Old Ea	Funeral	Home_P.	Α.	21221
	Physician /Medical Examiner	ner	23a. Parl 1. Enter the disease, or companies took, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, y, leading to the list of li	ilications that caused the dealine cause on each line. a. Respicación de la consecución del consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecución de la consecuci	th. Do not enter	Foilul	such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
,00/00	The law requires that the death certificate be executed attending physician and steep 2 should be detached for use as the burial-transit.	fedicai Examiner	resulting in death) Last	Due to (or as a consect	Quence of):	b(0515				
.O. DOX	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of to 9□Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
corus, r	equires that en signed b		Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause given	in Part I.	23e. Did toba		e to the cause of death? Probably 4 Unknown
	sician: The law r s certificate has be lirector, page 2 sh	e Completed by	25. Was case referred to medical			2	6. Place of Death	-	ed? deat	e autopsy findings available to completion of cause of 1? res 2 No
5	hysici this cer al direc	ToB	TE THE GENO		ER/Outpatient	t 3□ DOA Other:	4 Nursing Hom		ce 6 □Other (5	Specify)
	tending Physicath. tor: After this the funeral di	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		s 2□No	8d. Describe how		
2	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page		4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy) 			City or Town,	State)	r Rural Route Number,
	ne Hos	Medicai	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time, restigation, in my opin	date and place, a ion, death occurre	nd due to the cau d at the time, dat	se(s) and manne e and place, and	r as stated. due to the cause(s)
	To the Comp	Ĕ	29b. Signature and title of certifier	1 11.	/	29c. License n		290	d. Date signed (M	onth, Day, Year)
	X		30. Name and address of person who o	full with completed cause of death (Iter	7 23a) (Turns 5		70000	_	3/7/	05
	Sta	to:	DC Joseph Herch	2 registrar's Signal	Fron	Klin Soll	wre Dr	iveBo	- It mose	= MP 21237
	Reg <u>i</u> str		MAR 0 8 200	5 he sure	& Sou	ende				

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** March 1, 2005 10:15 P M Harry Mills /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville 1920 Lismore Lane If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12XM 2□ F Yrs. 86 1918 Director 215-14-1863 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore <u>Catonsv</u>ille 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 1920 Lismore Lane 21228 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nent of Haalth and Mental Hygiana. ant: if item 27 is marked other ther 12 Fraud Investigator Credit Card item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Mills Irene Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1920 Lismore Lane; Catonsville, MD 21228 Keith Mills Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Pimportant: if ite eny injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 3/7/05 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery Boonsboro, Maryland 21. Signatu of Funera Se 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue: Catonsville, MD 21228 23a, Part 1. Enter the disease Parti. Enter the disease, or complications that ceuse shock, or heart failure. List only one cause on each list. Dig not enter the mode of dying, such as cordiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner i or Attending Physician: The law requires that the death certificate ba executed after death.

Director; Attar this certificate has been signed by the attending physician and the burial-Box 68760 Physician/Medical as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D04971 3/2/05 30. Name and address of pers empleted cause of death (Item 23a) (Type, Print) 413 Commonwealth Avenue, Baltimore, MD 21228 Miguel A. Heredia, M.D, 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year MITCHELL MILDRED 2005 5.45 P.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Bultimore 5401 Old Coart RA Northwest Kandalls town der 1 Year If Under 24 Hrs. 8. C 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days 1 ☐ M 2 🗓 F 214-22-5355 78 July 6, 1926 | Maryland Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State Baltimore 1 ☐ Yes 2X No Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1128 Newfield Road 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant 12 Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Dulaney Mildred Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Elaine Avenue; Westminster, Maryland 21157 Tom Mitchell son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) New Cathedral Cem. 3/9/2005 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dartuctie draycel Chronie Immediate Cause (Final lar disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ₩ No 9 Unknown 9 Unknown Partil. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use contribute to the cause of death? drigare 14 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 1 Natural 5 Pending

Pnysician /Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

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"natural", or Items

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other then "natural", or Ite

Baltimore, Maryland 21215-0036

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permit. Page Department of Important: If any injury or once.

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Funeral

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physician and s the burial-transit use as signed by the attending the detached for use as page 2 s

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. o

Physiclan/Medical þ Completed

Certification;

2 Accident

3 Suicide

29a. Certifier

4 Homicide

State Registrar 29b. Signature and title of certifier

М

1 Tes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Ham Award T. Ham T. Ha

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Lawgwamh 31. Date filed (Month, Day, Year) MAR 0 8 2005

investigation

6 Could not be determined

egistrar's Signature

	•	1 - State Registrar					Cer	tificate of	Death		Reg. No	. 20(05 07672
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Registrar

State

Michael Gardyn D.O.

31. Date filed (Month, Day, Yehr)

MAR 0 8 2005

Baltimore

2401 W. Behedere Ave, Bultimore MOZIAS

Simi Haspital

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 15 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 1 400 ms M FRAHCISD 05 Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Hall Anne Arundel Hos betal Aren Glen Burnie If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax **Funeral** Min Months Days Hours i⊠M 2□F 301-14-1197 82 Director May 17, 1922 Ohio Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Worls ?7 is marked other than "natural", or Nems 23a or 28a-f shot traumatic avent, the Medical Examiner reset be neithed at 1 ☐ Yes 2 No Anne Arundel Glen Burnie Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21060 7466 Furnace Branch Rd. Apt. 206 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Insurance Salesman 12 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fill of Health and Mental H fitem 27 is marked ot Miller Cora Gnepper ပ Wesley 0. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 Glen Burnie, Md 7466 Furnace Branch Rd. Apt 206 (wife) Sara Miller other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State injury or Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 03/07/05 21. Signature of Funeral Service Lizensea 22. Name and Address of Facility MCCULLY-POLYNIAK FUNERAL HOME P.A. 3204 Mountain Road, Pasadena, Maryland 21122 unx! 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hear **Physician** io rgestive /Medical Due to (or as a consequence of): **Examiner** Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 aneer Be Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. alui liller 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown dis case 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28b. Time of 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. To the Hospital or Attend within 24 hours after death To tha Funeral Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

ashre

MAR 0 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

How House House

2005

Jay

31. Date filed (Month, Day, Year)

egistrar's Signature

146596

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day MARCH MARCH **Physician** 2005 2:40p Ruth Arlene Mosiman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner Heritage Harbor Nursing Home Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 14, 1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 1 M 2 TF Months 560-07-7474 87 Kansas Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28s-f show r than "natural", or Items 23a or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8 Silverwood Circle #10 21403 USA death (Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No ff Yes, Give A Year or Dates: 14. Race - American Indian, 11. Maritaf Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Secretary School Library 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked ofth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Claude Attridge Georgia Spellman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 Silverwood Circle #10 Armapolis, MD 21403 Ruth Ann Levin/daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Metro Crematory, Incl. 3/7/05 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juner Service Licensee

Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** e o or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, phys the b as IF FEMALE: nse i 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Dav ğ 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 💯 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 212 No 2 SNo 1 Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Dther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After t Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide à 4 🗌 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title Road #106 Ochester MD 21113 completed cause of death (Item 23a) (Type, Print) . Registrar's Signature State

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No. 005 07	677
-	Physici /Medic	ai	to Frilly New West State of the state of any land	Day Year 3:	of Death
	Examir Funeral Director	er	5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of the part	- 1/0	or Foreign
2	show show	<u>_</u>	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside	City Limits
	with the M 3a or 28a-f it be notifite	Funeral Director	10e. Street end Number 10f. Zip Code 21212	10g. Citizen of What Country?	
020	filed within 72 hours aftar death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Exeminar must be notitled at			14. Race - American Indian, Black, White, etc.	
21215-0020	be filed within 72 hours aft ital Hygiene. d other than "natural", or event, the Medical Expri	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Buyer	16b. Kind of Business/Industry Retail	
Maryland 2	should be filed and Mental Hygis marked other umatic event, II	To Be Co	17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	iddle, Maiden Sumame)	
	d 2 sho th end 7 is m traum	•	19a. Informent's Name/Reletionship (Type, Print) David E Cruise Son 19b. Meiling Address (Street and Number or Rurel Route N 403 E Lake Avenue Baltimore		
Baltimore,	Peges 1 nent of Ha ant: If iten ary or oth		20a. Method of Disposition 1	20c. Location - City or Town, State Baltimore, Mary I	and 21
Balt	pemit. Peg Department important: I any Injury o pnce.		Leunis Stephen Kenaks 6500 York Road B	Baltimore, Maryland 21212	
1	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es arconsequence of):	Onset and	etween
	certificate ba axecuted ding physician and se as the bunal-transit	/Medical Examiner			
.O. Box	he deeth cert the ettending thed for use	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b.	Did tobacco use contribute to the cause	of death?
ds, p.	res that the de signed by the e	þ			Unknown
of Vital Records,	The law requires that the deeth cerate has been signed by the ettendir page 2 should be dateched for use	Completed	24a.	Was an autopsy performed? 24b. Were autopsy available prior completion of deeth?	to
		Be Co	25. Was case referred to medical 26. Plece of Death (Check of particular part] No
on of \	g Phys ter this neral di	tlon: To	- Value of the state of the sta	Residence 6 □Other (Specify) ribe how injury occurred	
	daat daat ctor: y the	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locati City of	on (Street and Number or Rural Route Nu r Town, Stete)	mber,
	To the Hospital or A within 24 hours after To the Funeral Dire complataly filled in b	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time.	the cause(s) and manner es stated. ime, date and place, and due to the cause	(s)
	vithin 2 To the compla	Ž	29b. Signature end title of certifier 29c. License number DH76HH	29d. Date signed (Month, Day, Year) Mouth 6 2005	
	,	X	30. Name and address of person with completed cause of death (Item 23e) (Type, Print)	1019 MD 21201	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Restrar's Signature MAR 0 8 2005		

DHMH 16 Rev 6/95

	1	For State Registrar	State of Maryla		ment of H			giene Reg. No.	005	07678
Physician /Medical	L	. Decedent's Name (First, Middle, Last, Earl William	Mullinix	Sr.			2. Date of De Month	Day	Year 8005	3. Time of Death 7:38PM
Examiner Funeral Director	5	212-32-3120	IDEL HOSE	ITAL (Under 1 Year onths Days	Location of Dea ORN/ If Under 24 Hr Hours Mir	s. 8. Date of Bir	A A th ay, Year)	9. Birth	
with the Maryland or 28a-f show be rivilled at	1	Jsual Residence of Decedent 0a. State 10b. County MD Anne Arun		ity, Town or Location	on					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ler death v	1	0e. Street and Number 7984 Cross Creek 1. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Drive 12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13. Was	Of. Zip Code 21061 Decedent of His, specify Cuba Yes 25 No	ispanic Origin? (n, Mexican, Pue Specity:	Specify Yes or Norto Rican, etc.))- 14.	USA Race - Amer Black, White	ican Indian, , etc.
121215-0036 led within 72 hours alf sydems yighen "natural; or nit, the Maulcal Expost Completed by F		15. Decedent's Edu (Specify only highest grade	cation		of work done of NOT use retired	ation during most of wo	orking	16b. Kind	of Business/Ir	ndustry
Maryland 212 Ashould be filed with the and Mental Hygiene. The marked other the traumatic event, that	1	7. Father's Name (First, Middle, Last) Unknown		Car Me	cnanic	18. Mother's Na	nm <i>e (First, Middle</i>)		COMO ti v	7e
ore, Mary		19a. Informant's Name/Relationship (Ty Earl W. Mullinix, 10a. Method of Disposition 1 (28) Urgeniation (12) Fig. 15	Jr./Son	7988 Cr Place of Dispositio gemetery, gramato	oss Cre	ek Driv	e, Glen Date	Burnie		1061 own, State
Baltimore, Ma permit. Pages 1 and 2. Department of Health at Important: If tiem 27 is eny injury or other trau	2	4 Donation Specify) 21. Signatur Licens		22. Na	ime and Addres	ss of Facility		1 S	econd	Ave. S.W. ie, MD 2106
Deposition and special and special and special and special and special and special examiner cal Examiner	1	23a. Part1. Enter the disease, or complished, chair failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, famy, reading to ammediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	Due to (or as a consection of the consection).	Obstruction quence of):	6		Disea			Approximate Intervat Between Onset and Death
Box 6876(auth certificate be attlending physicia for use as the but		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	nancy al death 3 DEct	opic pregnancy ner (specify)			23d	I. Date of deliv	ery Day Year
ds, P.O. uires that the dt signed by the id be detached d by Physic		9 ☐ Unknown		sulting in the under	lying cause give	en in Part I.	27.0	obacco use		the cause of death?
al Records The law require Tate has been signage 2 should be	-								4b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by		7. Manner of Death	lospital: 1 ☐ Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	DOA Othe	at Nursing	ath Check on o	dence 6		fy)
Division catending P rs after death. a) Director: After ted in by the funera		1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street,	M 1 🗆 Y	/es 2 □ No	28f. Location (S City or Tox	Street and N vn, State)	lumber or Rur	al Route Number,
Hospi 4 hou Funer ety fill ical	2	29a. Certifier (Check only one) 1 Cartifying Physical Examination	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, death occ ation and/or investi	curred at the tim gation, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as s	stated. o the cause(s)
To the within 2 To the complete	L	9b. Signatura and title of certifier	()	ND		0108		29d. Date s	igned (Month,	
State Registrar		10. Name and address of person who come the come of th	7845 Oak	wood ko		ù 200	bus B	unu	MÞ.	21061

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and Mental Hygiene 05 07679 1- For State Registrar Certificate of Death Reg. No.							07679		
	Physici		1. Decedent's Name (First,	Middle, Last)	Lee			Mossix	2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not ins	titution, give s			4b. City, Town, o	r Location of Death		4c. County of Dea	ath
				Medi				timore	100111		
	Funeral Director		5. Social Security Number 230 – 46 - 775	6. Sex		rs. last birthday) & Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	rthplace (State or Foreign country)
	p. ,		Usual Residence of Decede	ent	100	City, Town or Lo				1120	10d. Inside City Limits
	Aanyia f shov	٥	•4	ounty		n.					1, Yes 2 No
	r 28a-	rect	10e. Street and Number		D/	+LT1M0	10f. Zip Code		11	0g. Citizen of What C	Country?
	th with	aiD	122 NOR	+h /+	IGHLAND	AVENU	c 212	24		4.51	A .
	tema tema	Funeral Directo	11. Marital Status	1	2. Was Decedent Ever in	1 U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Itema 23e or 28e-f show other traumetic event, the Madral Examinar must be notified at	by	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		Armed Forces? 1 Sayes 2 No K If Yes, Give Year or Dates	DRCAN	1□ Yes 2 No	Specify:		Specify:	Shite
5-0036	72 hou	Completed	15. De	cedent's Educ highest grade	ation	16a. Dece	dent's Usual Occup	ation during most of war	rkina	16b. Kind of Busines	s/Industry
21	within ene. than "	mple	Elementary/Secondary (College (1-4or 5+)	life.	kind of work done DO NOT use retired		9	Scenor	Motors
d 21	filled v Hygie other t		17. Father's Name (First, N	liddle, Last)	 .		PAIN		ne (First, Middle, M		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
land	ould be Mental arkad o	To Be	JOHN	Rol	pert r	10RRIS	5	Bes			15/e++
Mary	and Menris marks	-	19a. Informant's Name/Re							City or Town, State,	
-	1 and 2 Health a lem 27 is			11en M	ORRIS - Spoi			1 1+19h1	AND AVE	NYC BAIL	Hd 21224
Baltimore	0 0		20a. Method of Disposition 1 ■ Burial 2 □ Crem		I	o. Place of Dispo cemetery, crei	matory`or other plac			20c. Location - City o	2.3
ij	permit. Pag Department Importent: I eny injury o		° 4 ☐ Donation 5 ☐ O			ACRED 1	Hot J	CSYS MAR	ch 9, 2015	BA /4/14	ORE, MARYANS
Ba	permit. Departr Importe any inje) // das	1/1			CHARLES	3.2	ANNINO	Handay	sed Morticin
			23 Land Enture disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only the cause on each line. Approximate Interval Between								
	Physician /Medical Examiner		Immediate Cause (Final disease or condition								Onset and Death
			resulting in death)		Due to (or as a consequent of):						O promise and the contract of
	Lxammer	<u>-</u>	Sequentially list conditions	, b	b						
$\sqrt{}$	uted d ansit	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	1							
0	be executed sician and burial-transit		resulting in death) Last		Due to (or as a con-	sequence of):					
8760	cate be ex physician the burial	Physician/Medical		0							
9 X	ding p	/Me	IF FEMALE:	. 2	3c. If yes, outcome of pre	onancy				23d, Date of de	pliven
Box	that the death certifica ed by the attending pla detached for use as t	iciar	in the past 12 months? 1 \[\text{Live birth} \ 2 \] \[\text{Fetal death} \ 3 \] \[\text{Ectopic pregnancy} \] 1 \[\text{Ves} \ 2 \] \[\text{No.} \] 4 \[\text{Pregnant at time of death} \ 5 \] \[\text{Other (specify)} \]					Month	Day Year		
P.0	at the by the	hys	9 🗆 Unknown		9□ Unknown						
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	e Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e						Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown		
orc									- Sec.		
Records,	The law ate has l								24a. Was a autops perforn	y prior to ned? death?	autopsy findings available completion of cause of
Vital			25. Was case referred to n	nedical				26 Place of Dea	1 ☐ Yes 2 ath (Check only on		s 2 🗷 No
f Vi	Physicien: rthis certific ral director,	To B	examiner? 1 ™ Yes 2□ No	Н	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	-31.00		nce 6 Other (Sp	ecify)
n of	ding Ph J. After th funeral	on:	27. Manner of Death 1 Natural 5	Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
Division	Attending r death. actor: After by the fune	icati	2 ☐ Accident 3 ☐ Suicide 6 ☐	nvestigation Could not be	e and Blace of Injury. At home form street		M 1 Yes 2 No		29f Location (St	8f. Location (Street and Number or Rural Route Number,	
Div	after of Dirac	Certification:	4 Homicide	determined	building, etc. (Sp.		eer, ractory, office		City or Town	, State)	ndiai noute Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C									
	To th withir To th	Me	29b. Signature and title of	certifie	1-21		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
		E	> CM.	1 un	TELY		019	714	3	17/05	
	H		30. Name and address of p	erson who co	mpleted cause of death (_		D		/	
	Sta	ate	31. Date filed (Month, Day	Year)	32. Pigistrar's Si	gnature	D. Aye	REHIM	rose, MI	21224	
	Regist		MA	R 082	005 Jan	A A	The state of				

			For State Registrar	State of Maryland / Dep	artment of Health	and Mental Hy	^{/giene} 005 07680		
			Registrar Decedent's Name (First, Middle, Last		rimeate of Deat	2. Date of De	Reg. No. eath 3. Time of Death		
П	Physicia /Medic Examin	an	1. Decedent's Name (First, Middle, La.	51)		Month	Day Year		
		al	James Croner M. 4a. Facility Name (If not institution, give		4b. City, Town, or Location	March	1, 2005 1:30 P M		
		er	Oak Crest		Parkville Baltimore				
	Funeral		5. Social Security Number 6. S	9		er 24 Hrs. 8. Date of Bi	rth 9 Birthplace (State or Foreign		
	Director		232-22-7769	M 2 F Yrs. 87	Months Bays Hours	March (
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits		
	Mary f sho	ğ	Maryland Baltim	ore Parkv:	ille		1 ☐ Yes § ∏ No		
	within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28e-f show he Mardical Exanditer must be mutified at	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?		
		a D	8832 Walther Boul	evard	21234		USA		
	deat	ner	11. Marital Status		Was Decedent of Hispanic Of If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No			
ဖွ	or its	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No	1 ☐ Yes 2 ☑ No Specif		2		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Introprenent: If tem 27 is marked other then "natural", or flems 23a or 28e-1 show eny injury or other treumatic event, the Maritical Examinative ust be rediffied at once.	d by	3 Widowed 4 Divorced	Year or Dates:	· · · · · · · · · · · · · · · · · · ·		WILLCE		
쟌		lete	15. Decedent's Ed (Specify only highest gra	ide completed) (Give	dent's Usual Occupation with his kind of work done during m DO NOT use retired)	ost of working	16b. Kind of Business/Industry		
21215-0036	l withi iene. r then	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ty Protection	n Manager	Railroad		
ğ	filed Hyg other		17. Father's Name (First, Middle, Last)			ther's Name (First, Middle			
<u> a</u>	uld be Aenta rked tic ev		James Croner M	usser, Sr.	E	dna Pearl	Phillips		
Maryland	and h		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Num	nber or Rural Route Numb	per, City or Town, State, Zip Code)		
≥,	and and ealth m 27		Judith Musser Ba	iley - Daughter 13	315 Marquis C	ourt, Fallst	on, Maryland 21047		
Baltimore,	ges 1 t of H If itel		20a. Method of Disposition 1 Surial 2 Cremation 3		matory`or other place)	Date	20c. Location - City or Jewn State		
Ë	t. Partmen rtent: njury		` 4 ☐Donation 5 ☐ Other (Specify	woodmere	Mem. Park	4 0 00	Huntington, Virginia		
Bal	permi Depa Impo eny ir		21. Signature of Funeral Service Licer	1 GAMES / N	2. Name and Address of Fac CCOMAS Funera	al Home			
			23a. Part1. Enter the disease, or com	plications that caused the death. Do not en	ter the mode of dying, such a	Road, Abing	rdon, Maryland 21009 Approximate		
	Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		í	Interval Between Onset and Death		
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequence of):	, Bacteria	al			
			Sequentially list conditions,	b					
		Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					
1	and trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):					
8760,	ate be executed hysician and the burial-transit	cal E		Due to (or as a consequence or).					
687	ficate p phys ts the			_ d					
Вох	certif nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery		
œ.	death e atte		in the past 12 months?	4 Pregnant at time of death 5 [□Ectopic pregnancy □ Other (specify)		Month Day Year		
P.O.	at the by th tache	hys	9 🗆 Unknown	9□ Unknown					
S, I	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Dther significant conditions of	contributing to death but not resulting in the L	inderlying cause given in Par		tobacco use contribute to the cause of death?		
ord			Sick sinus	syndrome			Yes 2 No 3 Probably 4 Unknown		
ec	e 2 sl	Completed	Advanced	Alzheimers Dis	sease	24a. Was	prior to completion of cause of		
E F	To the Hospilal or Attanding Physicien: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Be				1 Yes	ormed? death? 2☑No 1☐Yes 2☑No		
X			Be	25. Was case referred to medical examiner?	Hospital:	Out -	ce of Death (Check only		
o		1; To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	11 3L DOX 4		idence 6 Other (Specify) how injury occurred		
lo		tlon	1 ■ Natural 5 □ Pending 2 □ Accident investigation		Work? M 1 ☐ Yes 2 [□No			
Division of Vital Records,	Atter	iffice	3 Suicide 6 Could not be determined		reet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
٥	lal or rs afte el Dir ed in	Medical Certification;	4 110/110/00	building, etc. (Opeany)			wii, otatoj		
	Hospi 24 hour Funer stely fills								
	To th within To the		29b. Signature and title of certifier		29c. License numbe	or .	29d. Date signed (Month, Day, Year)		
}	1		an- mone	i	05864	6	March 1 2005		
	4		30. Name and address of person who	completed cause of death (Item 23a) (Type,					
			8800 walther	Boulevard Parke	112 MD	21234			
	. Sta Registr	. 9	31. Date filed (Month, Day, Year) MAR 0 8 20	Registrar's Signature	ME)				

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day}2005 **Physician** March 3, 6:07 P. M Maxen 7n thony /Medical 4c. County of Death 4a. Facility Name (If not inditution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 24, North Arundel Hospital Birthpface (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☑ M 2 ☐ F 1917 Maryland 87 Director 213-05-6321 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County •how r than "natural", or itema 23a or 28a-f ehov the Medical Exactine must be notified at 1 ☐ Yes ※ANo Funeral Director Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21061 103 King George Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 941 11. Marital Status 1 Ves 2 No 1940-If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within in and Mental Hygiene.
7 ie marked other than * Colfege (1-4or 5+) Elementary/Secondary (0-12) U.S. Postal Service Mail Carrier 18. Mother's Name (First, Middle, Maiden Sumame) UNK 17. Father's Name (First, Middle, Last) UNK Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Glen Burnie, MD 21061 Department of Health a Important: if item 27 is eny injury or other trains once. 103 King George Drive Anthony P. Maxen / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar. 9, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland Crownsville MD Vet. Cem. 2005 permit. 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. Glen Burnie, MD 21061 421 Crain Hwy. SE 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one/cause on each line. Approximate Interval Between Onset and Death festive Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 250 lemic Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burral-transit anno that initiated events attending physician and resulting in death) Last Due to (or as a consequence of Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 Yes 2 No O 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 2 3 ☐ Probably 4 ☐ Unknown Yes 2 🗆 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an s certificate has t irrector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ 2H/Outpatient 3 ☐ DOA 29 No 1 🗆 Yes Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After t Division fniury or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by determined 4 Homicide 24 hours a To the Hospital (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200,6 address of person who completed cause of death (Item 23a) (Type, Print) 1 1600 Ste. 106 Burnic, MA Glen rain 31. Date filed (Month, Day, Year) 32 State MAR 08 2005 Registrar

ORIGINAL

		4	For L. State	State of N		d / Depa		of He	eaith a		ental Hygi	ene	005	076	582
			Registrar 1. Decedent's Name (First, Middle, Last)								2. Date of Death	1		3. Time of	Death
	Physicia		William E. Mc	Cuirk I	r						Month Februar	Day 21.	2005	7.50) PM
	/Medic		4a. Facility Name (If not institution, give s				4h City T	own or i	Location of	f Death	rebradi		ty of Death	7.50	, 111
	Examin	er			")		4b. City, 1		Air	, 004			rford		
			2211 Penningt		A (la rea l	la ad himbula . I	If Under 1		If Under 2	24 Hrs	9 Date of Birth)		laca (State (y Faraign
	Funeral		5. Social Security Number 6. Sex	M 2□F	Age (In yrs. I	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, Dec 31,	Year)	New	place (State of	ii i Oraigii
	Director		030-10-0730		87						рес 51,	191/	New	IUIK	
	pu k	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside C	ity Limits
	aryla	<u>-</u>	MD Harford				Air							1 🗀 Yes	2 No
	889-f	ctc			1						14)- Citizan e	of What Cour	eta.?	
	ith to	Director	10e. Street and Number	_			10f. Zip (C000			'	5 111121		iti y :	
	23a	E E	2211 Pennington 1						2101				SA		
	ep u	ne	11. Marital Status	12. Was Decede Armed Force	nt Ever in U. s?	S. 13.	Was Decede If Yes, <i>s</i> pecr	ent of His fy Cubar	spanic Orig n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,		
98	or l	by Funeral	1 Never Married 2 Married	1 XYes 2 [If Yes, Give			1 □ Yes 2	⊠ No	Specify:			Spec	cify: W	hite	
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Itame 23a or 28e-f ehow ha Madical Examiliar must be indiffied at	d b	3 Widowed 4 Divorced	Year or Date	s: '35	545					1.	IOL Kind of	Desire and de	also atas	1
5	72 h	Completed	15. Decedent's Edu (Specify only highest grade	cation e <i>completed)</i>		16a. Dece	dent's Usual kind of work DO NOT use	done d	ition uring most	of worki	ng	IBD. KING OF	Business/In	dustry	unk
2	Athin han	du	Elementary/Secondary (0-12)	College (1-4d	or 5+)	ıııə.									
	ygie ygie ygie ygie tr. th	ပိ		J			execu			r's Name	(First, Middle, N	taiden Sum	amel		
pu	tal H d otl	Be	17. Father's Name (First, Middle, Last)	1									amoj		
yla	should Men marke	2	William E. McGui								Lanigar				
Maryland	and and seum	. 1	19a. Informant's Name/Relationship (Ty			i	_				al Route Number,		vn, State, Zip	Code)	
	and salth n 27 er tr		Mary T. McGuirk/s	pouse		-			n Roa		el Air,		1015		
ore.	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ P	lamoval from Sta		lace of Dispo emetery, crei			9)		Date 2	20c. Locatio	n - City or To	own, State	
Ĕ	Page nent nt: H		'4 ☑ Donation 5 ☐ Other (Specify)	enioval nom Sta	1				1						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28e-f show amy injury or other traumatic event. The Madical Examinat must be instiffed at ance.	1	21. Signaluru di meral Servici Licens	ade M	rector	S21	2. Name and	Addres	s of Facility	Sard	655 W.	Balti	more S	treet	
Ö	Deparimpo any ir gard		100 mill	2/1/	Ne		altimo		-	2120				,	
	4.8		23a. Part1. Enter the disease, or compl	ications that caus	sed the deatl							st,		Approxima Interval Be	te
			shock, or beart failure. List only or Immediate Cause (Final	ne cause on each	inne.		. /		0	^	0) (2	Onset and	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a conseq	gel)	Tec	بدل	4	20	no for	()	en	2 5	day.
в	Examiner			540 (0)		22.700 0.7.								÷	
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	nsit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
	and al-tra	xar	resulting in death) Last	Due to (or	as a conseq	uence of):									
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687	Jeath certificate to attending physical of for use as the b			3											
×	ding se a	/Me	IF FEMALE:	23c. If yes, outco	me of preama	ancy						23d	Date of deliv	arv	
Box	death of atten	an	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnan	1 2 ☐ Feta	death 3	Ectopic pre						Month		Year
o.	0 0 2	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		10atii 3L	_ Other (spe	sciry/							
ď	requires that the de leen signed by the hould be detached	by Physiclan/Medl	Part II. Other significant conditions co	ntributing to deat	h but not res	ulting in the u	inderlying ca	use give	en in Part I.		23e. Did tot	acco use c	ontribute to t	he cause of	death?
of Vital Records,	Se un es	by				3	,				1 □ Ye	s 2 No	3 ☐ Proi	oably 4 🗆	Unknown
5	v requir been s	Completed													
ec	- 40	ğ				·					24a. Was a autops	v	b. Were auto prior to co death?	opsy findings impletion of i	available cause of
<u> </u>		Son									perform	No	1 Yes	2□ No	
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					-		of Deatl	n (Check only on	θ)			
7	Physic this ce al dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 🗆	ER/Outpatie	nt 3 DO	A Othe	9Γ: 4 □ Nu		me 5 eside			(y)	
	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	njury Day Year)	28b. Time o	of 28	8c. Injury Work	at c?		28d. Describe ho	w injury occ	curred		
<u>ō</u>	Attending or death.	atle	2 Accident investigation				М	101	Yes 2 🔲	No					
Division	er de	ti fi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building	Injury - At he, etc. (Specif	ome, farm, st	reet, factory	, office			28f. Location (St City or Town		mber or Rur	al Route Nur	nber,
Ö	tel or s afte el Dir	Certification:													
	ne Hospitel or Attend n 24 hours after death te Funerel Director: A		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam												s)
	To the Hosi within 24 ho To the Functional Completely f	Medical	one)	and manne	stated.	211011 4110201 11	angalloll,	III III O	JIIIOII, 00L						
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		,	(29c	. License	number		2	9d. Date sig	ned (Month,	Day, Year)	
			1 Wille	1 loto	1/		1	>	05	0	>1	2/	241	05	-
			30. Name and address of person who c	ompleted cause	death (Iter	n 23a) (Type	Print)				- 1		Wind Mount		
			200 E. 33rd Stree	t, Suit	e 650,	Balti	more,	MD	2121	18	Willia	m H.	B. Howa	rd, M)
	St	ate	31. Date filed (Month, Day, Year)	32.4Reg	istrar's Signa		ر فد								
	Regist		MAR 0 8 20	05	م معر	K A									

DHMH 17 Rev 1/2001

ORIGINAL

		4	For State Registrar	riea				land / De		ent of H	lealth :	and M	lental Hy		20	05	07683)
100			Decedent's Nam	ne (First, Middle	e, Last)								2. Date of De			V	3. Time of Death	
	Physicia	_	Mary Mc	Causlan	ıd								Month Februa	ry 2		Year 2005	7:50 PM	
	/Medic		4e. Fecility Name (t and nur	mber)		4b. Ci	ty, Town, o	r Location	of Death				y of Deeth		
	LAdmin	51	Joseph 1	Richey	Hospi	.ce				Balti	imore							
	Funeral Director		5. Social Security N 218-84-		6. Sex 1 ☐ M	2 ∑ F	7. Age (In 42	yrs. last birth Y	Month	der 1 Year ns Days	If Under Hours	Min.	8. Date of Bi (Month, D Mar 31	irth (ay, Year) 19	62	9. Birthi Coul Mary		
	p ,	-	Usual Residence of	of Decedent 10b. County			100	c. City, Town	or Location								Od. Inside City Limits	_
	anyla shov	7	MD	TOD. COUNTY			1.00		altimo	re							1∏Yes 2□No	
	he M	Director	10e. Street and Nu	umber					10f	Zip Code				10g. Ci	tizen of	What Cou	ntry?	_
	a or	古							101.	Lip otto	0101	,						
	eath	era	3403 Ma	ary Ave	12. \	Was Dece	edent Ever	in U.S.	13. Was De	cedent of H	2121 lispanic Oi		ecify Yes or N Rican, etc.)	0-		ce - Ameri		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 X Never Man		ried	Armed Fo 1 ∐ Yes If Yes, Giv Year or D	orces? 2 ⊠ No ve			pecify Cuba 2 X No	an, Mexica Specify		Hican, etc.)			_{ify:} white,		
Ş	hour	edic		15. Deceder	it's Education	on		16a. [Decedent's U	sual Occup	ation			16b. K	(ind of 8	Business/In	dustry	
5		plet		city only highe	st grade co	mpleted) College (1	1-40:5+\	- '	Give kind of life. DO NO	work done Tuse retire	during mo d)	st of work	ing					
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ַבַ	othe othe	Be C	17. Father's Name	(First, Middle,	Last)						18. Moth	er's Nam	e (First, Middle	e, Maider	1 Suma	me)		
Z jar	Aenta Aenta rked ric e	To	Dennis	Ellis	McCau	ıs1an	ıd						nia Sim					_
Maryland	short short	5 78	19a. Informant's N	Name/Relations	ship <i>(Type,</i>	Print)		19b.	Mailing Addr	ess (Street	and Numb	or Or Ru	al Route Num	ber, City	or Town	n, State, Zij	o Code)	
	and 2		Virgini	а МсСац	ısland	l/mot					<i>r</i> enue		imore.		-	214		
S 2/3	ages 1: ent of He nt: If iten y or oth		20a. Method of Dis 1 ☐ Burial 2 1 ☐ Donation	2 Cremation	3 □Remo	oval from	State	Ob. Place of cemetery	Disposition (, crematory (Name of or other pla	ce)		Date	20c. L	ocation.	- City or T	own, State	
65 Baltii	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnes.		21. Signature of F					tor					655 W	. Ва	1tin	nore :	Street	
944	\$ E		3a. Part1. Inter shock, The	the disease, opart failure. Lis	r complicati t only one c	ions that lause on c	aused the each line.	death. Do n	Balti ot enter the r			2120 s cardiac		arrest,		- 1	Approximate Interval Between Onset and Death	
	Physician	1	Immediate Cause	ion	_ a.	m	eta	Static	brea	st	CANC	el				-	4yrs	_
124	/Medical Examiner		resulting in death	,		Due to	(or as a co	onsequence o	f):								V.	
+	P #	lner	Sequentially list of if any, leading to cause. Enter Und Cause (Disease of	conditions, immediate derlying	Į b.–	Due to	(or as a co	onsequence o	f):									
۲ -	be executed ician and burial-transit	Examiner	that initiated even resulting in death	15	c	Due to	(or as a co	onsequence o	f):									-
760		a			_ d													
8 8	ng ph as th	Med	IF FEMALE:															
L Box	The law requires that the death certificate be extended to the strength of the strength of the strength of the strength of the strength of the burian rage 2 should be detached for use as the burian	by Physician/Medic	23b. Was deceded in the past 1 1 Yes 2 9 12 Onknow	i2 months? 2 □ No	23c.	1 Live	nant at time	Fetal death	3 Ectop	ic pregnanc (specify) _	y					ate of deliving	very Day Year	
Do d	res that the de signed by the a be detached to	Ph	Part II. Other sign		ions contrib	outing to o	death but no	ot resulting in	the underlyi	ng cause gr	ven in Pari	t I.	23e. Dio	d tobacco	use co	ntribute to	the cause of death?	
McCausland	uires t uires t signe												10	Yes 2	2 □ No	3 🗆 Pro	bably 4 Unknown	ı
S	w requir been si should	Completed											24a. W		245	. Were aut	opsy findings available)
ल के	The lavate has	E C											pe	topsy rformed? : 2 D N		death?	ompletion of cause of	
$\frac{1}{2}$		e C	25. Was case refe	erred to medic	al						26. Pla	ce of Dea	th (Check only		9		3.4	_
Z 3	ysician: ys certifications	0	examiner?			pital:	Inpatient	2 ER/Out	patient 3	DOA O			ome 5 Re		6 0	ther (Spec	in Hospice	_
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θ	endin sath. or: Afr	atle	2 Accident	inves	tigation				М		Yes 2[□No		(0)			-10	
	of or Att	Certification:	3 Suicide 4 Homicide	6 □ Could deter	mined	28e. Plac build	e of Injury ding, etc. (5	· Al home, la Specify)	m, street, la	ctory, office			281. Location City or 7	own, Sta	te)	nøer or Hu	ral Route Number,	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t	Medical C	29a. Certifier (Check only one)	1 Certify	ing Physici Il Examiner	r: On the I	ne best of m basis of ex nner stated	amination and	, death occu d/or investiga	rred at the tation, in my	me, date a opinion, de	and place eath occu	, and due to the red at the time	ne cause(e, date a	s) and i	manner as e, and due	stated. to the cause(s)	
_	o the	Me	29b. Signature ar	nd title of certif	ier						se numbe			29d. D	ate sign	ned (Month	, Day, Year)	
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			30. Name and ad	idress of perso	n who come	pleted cau	use of death	h (Item 23a) (Type, Print)	utan	<u></u>		imore	MD	2-i	201		
Н		ate	31. Date filed (M			1	Registrar's	Signature	N	16		Duci	in ore	1 17	- (201		
	Regist	ावा -		MAR 0	o Zuub		marie a	A.	A STORY	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene በ 🛭 🥤 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 07:10 AM Evick 2005 Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Hospita Agnes If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1⊠M 2□F 216-16-9887 1924 Director 80 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show Items 23e or 28e-f shov ner must be notified at 1 ☐Yes 2 No Director Catonsville Baltimore Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 U.S.A. 105 Smithwood Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 Divorced White neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) U.S. Army 12 Sergeant s t and 2 should be filed w I Health and Mental Hygier tem 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Algia H. Nash Mabel Evick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 l 9 Magruder Avenue Catonsville, Maryland 21228 Mary Capano (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If iter
eny injury or ott
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)

21. Signature Funeral Ser ice Licensee Lorraine Park Cem. 3-7-2005 Woodlawn, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsyille, 1630 Edmondson Ave Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cere BROUASCULAR **Physician** /Medical Due to (or as a consequence of): Examiner ere BROVASCU/AR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit generalized Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þe HEARTHAILURE DUERE CORDUARY 1 Yes 2 No 3 Probably 4 Unknown leted Chronic RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? Perender 724a. Was an Compl has autopsy performed ending certificate 1 ☐ Yes 2 ☐ No MADETES SPERGASTROINTESTINA 2 No Vital . Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA of this 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; Hospitel or Attending Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

To the

TTENDING

Physician

32. Paistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. MACHIRAN

Year)

29c. License number

16200

720-C MAIDEN Choice LA., CATORSVIlle 21228

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	laryland / De	epartment o Certificate				giene Reg. No. 00	5	07685)
	Physici	an	Decedent's Name (First, Middle, MTT DDED		017.4.77				2. Date of Dea Month	Day	Year	3. Time of Death)
	/Medic	al	MILDRED		OVAK	41. 01. 7.			MARCH (15 "	10:05	M
	Examin	er	4a. Facility Name (If not institution, 1710 FURNACE		7		wn, or Location BURNIE	of Death		4c. County		DET CO	
	Funeral				ge (In yrs. last birth	day) If Under 1 Y	rear If Unde	er 24 Hrs.	8. Date of Birth	1	9. Birthpl	DEL CO. ace (State or Forei	ign
	Director		216-28-3328	1□M 2MF	91 Yr	s. Months D	ays Hours	Min.	April Day	18,1913	Mar	71and	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1/	Od. Inside City Limit	te
	f sho	ō		Arundel		en Burni	e					1 □ Yes 2 🗷 N	
	1 the 1	Director	10e. Street and Number	Arunder	01	10f. Zip Co				10g. Citizen of W	hat Coun	try?	_
	or death with the Marylan Items 23e or 28e-f show		1710 Furnace Dr	cive		210	60			U.	S.A.		
	Items	Funeral	11. Marital Status	12. Was Deceder Armed Forces		13. Was Decedent	t of Hispanic C Cuban, Mexica	origin? (Specan, Puerto F	cify Yes or No-	14. Race Blace	- America		_
36	hours after death with the Maryland tural', or Items 23e or 28e-f show al Exarti actinust be incilled at	by Ft	1 ☐ Never Married 2 ☐ Marrie 3 █ Widowed 4 ☐ Divorced	lf Yes, Give Year or Dates		1 ☐ Yes 2 🛣					Whi		
9	2 hou	ted t	15. Decedent	s Education	16a. D	ecedent's Usual O	Occupation			16b. Kind of Bu	siness/Ind	lustry	
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Maryland 21215-0036	l be fit ntal H ed oth	Be	17. Father's Name (First, Middle, L	ast)			18. Moth		(First, Middle, Mulsh	Maiden Sumami	e)		
IZ I	2 should be and Mental is marked sumatic ev	은	James Healey 19a. Informant's Name/Relationsh	in (Type, Print)	19b A	Mailing Address (Si	treet and Numi				State Zin	Code)	_
	ロモアモ		Greg A. Novak	(Son)		712 Furn							
ore,	of Health Itam 27 other tr		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other				20c. Location -			
im	Page ment d ant: If		1 Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (Sp			aven Mem		03-09	9-05	Glen Bur	nie,	Maryland	1
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other once.		21. Signature of Fuperal Service L	Dame.	M	22. Name and A McCully- 3204 Mo	Address of Faci Polynia untain	ak Fur Road.	neral Ho Pasade	ome P.A. ena, Mar	ylan	d 21122	
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	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of)	:							
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Ö,	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or a	s a consequence of)	: -							
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ds, P	es be	by	Part II. Other significant condition	en 500 b	but not resulting in th	ne underlying caus	e given in Part	1.	23e. Did tol	1 /		e cause of death?	m
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l Records,	The lay ate has page 2	Completed							24a. Was a autops perform	med? pi	or to comeath?	sy findings available pletion of cause of 2 No	Θ
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Magnital				e of Death	(Check only on	7 0)			_
of	Phys this al dir	. To	1 Tyes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpai			Other: 4 N			ence 6 Othe)	
on	Attanding F r death. actor: After by the funer	tlon	1 Natural 5 Pending 2 Accident investiga	(Month, D	ay Year) Inju		Work? 1 ☐ Yes 2 ☐		od. Describe no	ow injury occurre	iu.		
Division of	I or Attandi after death. Diractor: A in by the fu	Certification:	3 Suicide 6 Could no	a ba	njury - At home, farm atc. (Specify)	, street, factory, of	ffice	2		treet and Numbe	r or Rural	Route Number,	
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	To the Hospital or At within 24 hours after of To the Funarel Dirac completely filled in by	edicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manners	of examination and/o	death occurred at the or investigation, in	he time, date a my opinion, de	and place, as eath occurre	nd due to the ca d at the time, d	ause(s) and mar ate and place, a	ner as sta nd due to	ited. the cause(s)	
	Vithi Comp	ž	29b. Signature and title of certifier	A.		_	cense number	9 1 1	2	9d. Date signed	(Month, E	ay, Year)	
,	1		Jonathan	Johnson	MO	77.32	2338	5//	3	17/	200	5	
4	1,		30. Name of address of person w. Jonathan Form	an, MD	1404B S	, Crain	304 6	lon B	vrnie	110	126	/	
13	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8	2005 32 Jegis	trar's Signature	Coule				-			

Denald 12than Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

.3			Please	-					Ensure Al	•	-	gible.	
		For State Registrar	1478 Tax						lealth and M Death	lental Hy	-	005	07686
Physici	an	Decedent's Nam	ie (Filst, Middle, L	M #19a ast)	PER	INF		3/08/6 5 ^{0f} J	1	2. Date of De		Year	3. Time of Death
/Medi	cal	4a. Facility Name (DONALD If not institution, a	ve street and n	umber)		2	NATHAN 4b. Citv. Town, o	r Location of Death	March	7	005 nty of Death	1000 A M
Examir	ier	Marylan	nd Grene	ral K	1056	1/10	l	Baltim	ore CT+	y		-	N/A
Funeral Director		5. Social Socurity 1		Sex 1⊋M 2□F	7. Age	71	ast birthday) Yrs.	Months Days	Hours Min.	JUL. 22	th ay, Year) 1933	9. Birth	place (State or Foreign htry)
. p		Usual Residence of					, Town or Lo	cation		002.22	,1500	1	10d. Inside City Limits
Maryll	tor	MD		IMORE				GS MILLS					1 □Yes 2 □ No
pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show apply injury or other traumatic event, the Muchael Examilier is use the notified at once.	Funeral Director	10e. Street and Nu		I DDIVI				10f. Zip Code	01117		10g. Citizen o	of What Cou	,
death ms 234	nerai	9305 GF	ROFFS MIL	12. Was De	cedent E	ver in U.	S. 13. \	Was Decedent of H	21117 lispanic Origin? (Spe an, Mexican, Puerto	city Yes or No	o- 14. R	lace - Ameri	
s after	by Fur		ried 2 Married	If Yes, C	2 (X)N Sive	lo		rYes, specify Cuba I□Yes 21XINo	Specify:	Hican, etc.)	Spec	lack, White, cify:	etc. WHITE
2 hours	ted b	3 Widowed	15. Decedent's i	Year or ducation	30-77			lent's Usual Occup			16b. Kind of	Business/In	
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NCAI Y ICA 10 2 should 11 and Men 27 is marke 17 traumatic		19a. Informant's N	ame/Relationship (ARFN / F	IXIL FRI RIEND	END				a <i>nd Number or Rur</i> a IILL_DRIVE				·
es 1 and of Health of Health fitem 27		20a. Method of Dis			n Stata	20b. P	lane of Diese	sition (Name of natory or other place	1 -	Date	20c. Location		
t. Pages rtment of I rtant: If ite		` 4 ☐ Donation	5 ☐ Other (Spec	ify)	ii State	OHE			AL 03/06				OWN, MD
permit. Departn Imports any Inju		21. Signature of F	uneral Service Lic	ensee					ss of Facility SOL ERSTOWN R				
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the dear	ysicia	in the past 12 1 ☐ Yes 2 9 ☐ Unknown	□No		gnant at	time of de		Other (specify)			, , , , , , , , , , , , , , , , , , ,	Month	Day Year
s that the	by Ph	P II. Other signi	ficant conditions	contributing to	death bu	it not resu	ulting in the u	derlying cause giv	en in Part I.	23e. Did t	obacco use co	ontribute to t	he cause of death?
require een sig	eted t	M. 11-1	ue ro	nac .	DIS	lu=		Quiber	28	10	Yes 2□No		18
he law he has b ige 2 si	Completed	11/12/11/	us	,				-		24a. Was auto perfo	ormegi?	death?	psy findings available mpletion of cause of
itan: T staificat ctor, pe	Be Co	25. Was case refe	rred to medical			<u> </u>			26. Place of Death	1 ⊔ Yes	2/2(No	1 🗆 Yes	2□ No
Physic Physic rthis co	2		No	-	Inpatier		ER/Outpatien		4 Nursing not		dence 6 🗆 C		y)
arth. rr: After	ation	1 Natural 2 ☐ Accident	5 Pending investigati		nth, Day	Year)	Injury	Wor	k? Yes 2 □No		non injury coo		
or Atte	Certification:	3 🗌 Suicide 4 🗎 Homicide	6 Could not determine	4 288. Fla	ce of Inju ding, etc	ry - At ho . (Specify	me, farm, str	eet, factory, office		28f. Location (City or To		mber or Rura	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier	1 Certifying F	hysician: To t	ne best o	f my kno	wledge, death	occurred at the tin	ne, date and place, a	and due to the	cause(s) and	manner as s	tated.
the He	Medical	(Check only one) 29b. Signature and	1	and ma	nner sta	examinat ted.	ion and/or inv	29c. Licens	pinion, death occurre	ed at the time,	29d. Date sign		
To To		250. Signature and		110)			89	1526		3/3	3/05	Day, rear)
15		30. Name an add	ress of person who	completed ca	use of de	ath (Item	23a) (Type,	Print)	and for	enie!	0 1	120	to 0
Sta	ate	31. Date filed (Moi			Registra	r's Signa	ture	11mg10	vice ch	JIKKU	u M	UPPI	100
Regist	rar	M	AR 0 8 20	05	dian.	N.	Asia	25					

			1 - For State Registrar	State of Ma	arylan			of Hea		•	giene 00	5 0768	7
	Physici /Medi		1. Decedent's Name (First, Middle, Las OLIVER RAND	,	WE	NS				2. Date of De Month MARC	Day	Year 9:40 P	M
	Examir		4a. Facility Name (If not institution, give BALTIMORE 5. Social Security Number 6. Se	VA MEZ) I C A	CENTER L last birthday)	4b. City, T	ALTIV	noRE Jnder 24 Hrs.	8. Date of Bir	4c. County of	of Death A 9. Birthplace (State or Fore)	ion
	Funeral Director			□M 2□F	85	Yrs.	Months		ours Min.	(Month, Da 01-07-19	y, Year)	Maryland	<i>yn</i>
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				·	10d. Inside City Limit	ts
	Man Fied	ţ	MD NA			Balt	imore					1 X Yes 2 □ N	ю
	r 28e	Director	10e. Street and Number		1		10f. Zip (Code			10g. Citizen of W	hat Country?	
	h wit	al D	1100 Pennsylvania Aver	nue					21201		US	A	
036	be filed within 72 hours after death with the Maryland that Hygiene. Ided there than "netural", or Items 23a or 28e-1 show od other than "netural", or Items 23a or 28e-1 show event, the Medical Exertains roughly had not	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Decede f Yes, specif	37	ic Origin? (Spexican, Puerto	ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, c, White, etc.	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "netur vent, the Mydical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12		5 +)	(Give life. l	dent's Usual kind of work DO NOT use stodian	done during retired)	g most of work	ing	16b. Kind of Bus		
land 2	2 should be filed and Mental Hygis Is marked other raumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Thomas Owens					18.	Mother's Nam Sara Ca		, Maiden Sumame		
ary	should b and Ment s marked umatic e		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street and N	lumber or Rur	al Route Numbe	er, City or Town, S	State, Zip Code)	
ž	alth a		Stephanie Owens/ Daugh	iter		1900 B	raddish	Avenue	Baltimo	ore, MD 2	1216		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic QRCB.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		0	lace of Dispo emetery, cren ison Fo	natory`or oth	ner place)	03-11-	Date -05	20c. Location - C	ills, MD	
Balt	permit. Departi		21. Signature of Funeral Service Licen	Jones				Address of leral Ho	•	638 N. G	ilmor St. 1	Baltimore, MD 21	21
	Pnysician /Medical Examiner		23a. Part. Enter the disease, or composition shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused one cause on each line. a	10. ATI	NF		(MOA		or respiratory a	rrest,	Approximate Interval Batween Onset and Death	
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as d									
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rds, P	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death b		ulting in the un		use given in I	Part I.	23e. Did to		oute to the cause of death? Probably 4 □Unknow	n
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Division of	of or Atten after deal Director: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At ho c. (Specily	ome, farm, stre				28f. Location (S City or Tow	Street and Number vn, State)	r or Rural Route Number,	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred at restigation, in	the time, da	te and place, , death occurr	and due to the o	cause(s) and mani date and place, an	ner as stated. nd due to the cause(s)	
	To the Comp	Ň	29b. Signature and title of certifier	,			29c.	License num	ber			(Month, Day, Year)	
)			Jerle !	5			F	185	44		MARCH	7 2 2005	
	2+1		30. Name and address of person who de	D., 10 N	GK	CEENE	ST.				0 212		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 200	22. Registra	ar's Signat	ture	K)			,			

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			1 = For State Registrar				rtificate of				Reg. N	/ 1115	0.	7688
	Physici	200	Decedent's Name (First, Middle,	Last)						2. Date of De	eath Da	ay Yea		Time of Death
	/Medic		Hei-Young to	201						3	-	3 200	59	:45 A-M
	Examin	er	4a. Facility Name (If not institution,	0	ilera	1.1	4b. City, Town,	1.	n of Death			c. County of De	(F)	
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	Director		305-48-8084	1□M 2፟MF	74	Yrs.	Months Days	s Hours	Min.	(Month, Da	ay, Year	1930 Ko	Country) ` rea	State or Foreign
	pu &		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	cation							-14- 01- 11-11-
	Aaryia f sho	ō		,										side City Limits ☐ Yes 2 ☑ No
	28e-	Director	Maryland Howard 10e. Street and Number	<u> </u>	Cla	rksvi	10f. Zip Code				10g. C	itizen of What		
	h with		5900 Whaleboat	Court #20	07		21029)				U.S.A.		
	ems ?	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of If Yes, specify Cu	Hispanic (Origin? (Sp	pecify Yes or No		14. Race - Ar Black, Wi		dian,
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and	be filed tal Hygi d other event, t	Be (17. Father's Name (First, Middle, L.	ast)				18. Mot	ther's Nam	e (First, Middle	, Maidei	n Surname)		
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<u>a</u>	d 2 should th and Mer ?7 Is marke treumatic		19a. Informant's Name/Relationshi Yoo I. Peal (Husband)			ng Address <i>(Stree</i> Whalebo				-			•
ค์	s 1 and if Health item 27 other to		20a. Method of Disposition	ildsballd)	20b. Plac		osition (Name of matory or other pl			Date		ocation - City		
Ē	8 = 5 8 = 5		1 ☑ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Spi				n Cemete	ı	3-5-	-2005	Marr	iottsv	i 110	MD
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X Q Q	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnand Other (specify)	су				23d. Date of d	lelivery Day	Year
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ς, Τ	w requires that the sbeen signed by the should be detache	ру Р	Part II. Other significant condition	s contributing to death be	ut not resulti	ing in the u	nderlying cause g	iven in Par	rt I.	23e. Did t	tobacco	use contribute	to the caus	se of death?
cord	requir een si nould	ted	Vascular				Juscu	Han	>)	1 🗆	Yes 2	No 3□1	Probably	4 Unknown
ته	aw as b	ompleted	pulmonari		91110	9513				24a. Was auto	DSV	prior to	o completic	dings available on of cause of
T o	Th ate pag	O	_ Chronic	Menal F	Pailu	ure				1 ☐ Yes	ormed? 2 X No	death?		0
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000	endin sath. or: Aft he fur	atlo	1 Natural 5 Pending 2 Accident investiga	tion	<i>y</i> 70diy	Hijary		Yes 2	□No					
UNISION	el or Attending F s atter death. Il Director: Atter id in by the funer	ertification;	3 Suicide 6 Could no 4 Homicide determin		ury · At home c. <i>(Specify)</i>	e, farm, str	eet, factory, office)		28f. Location (. City or To:	Street ar wn, State	nd Number or F e)	Rural Route	Number,
	spit ours	O	29a, Certifier 1 Certifying	Physician: To the best	of my knowle	edne deatl	Occurred at the	time date	and place	and due to the	causo/s	and manner	as stated	
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medical E.	kaminer: On the basis of and manner sta	f examination ated.	n and/or in	vestigation, in my	opinion, de	eath occuri	red at the time,	date an	d place, and du	ue to the ca	
	To the within comp	Ň	29b. Signature and title of certifier	10-	na. I).	29c. Licen	se numbe		1	29d. Da	ate signed (Mor	nth, Day, Y	ear)
/	do		•	400	101.3		ν	50	5 5	1	m	arch	3,0	1005
5	`		30. Name and address of person w	10780 I	eath (Item 2)	3a) (Type,	29c. Licer D Print) Lige	Rd,	Co	lumb	ia,	me	210	944
7,	Sta Registr		31. Date filed (MoAth, Day, Year) MAR 0	8 2005 - 32. Registra	ar's Signatur	by de	Cost							

		1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F rtificate of			giene (05	07689
O	aia	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ith Day	V	3. Time of Death
Physi /Med		ROSEANNE	PAI	NKOW			3	2	2005	8:53 P ^N
Exam	iner	4a. Facility Name (If not institution, giv		7)	4b. City, Town, o	r Location of Deal	th	4c. Cou	nty of Death	
		785 Evergreen 5. Social Security Number 6. S			If Under 1 Year	Severn			nne Ar	
Funera Directo		-	1 □ M 2X0 F / . A	ge (In yrs. last birthday) 56 Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	9. Birthpi Coun	lace (State or Foreig try)
	4	Usual Residence of Decedent					5/8/19	48		MD
rylan how		10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits
Be-f s	cto	MD Anne	Arundel			Severn				1 ☐ Yes 2X No
with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Coun	try?
s 23e	ral	785 Evergreen			<u></u>	21144				JSA
LIZ 13-UU30 d within 72 hours after death with the Maryland piene. r then "neturel", or ttems 23e or 28e-f show the Medical Exanting count be rectified at	by Funeral	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give	KNO S	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. R B	ace - America lack, White, e	etc.
INIAI YIAIIIQ Z I Z I 3-UU30 d 2 should be filed within 72 hours afi th and Mental Hygiene. 27 le marked other then "neturel", or treumatic event. The Neulical Exami	ed	15. Decedent's E	Year or Dates:		dent's Usual Occup	ation	_	16h Kind of	Business/Ind	ite
within 72 ene.	Completed	(Specify only highest gra	ade completed)	(Give	kind of work done DO NOT use retired	during most of wo	rking	TOD. KING OF	Dusiriess/irio	iustry
e filed within all Hygiene.	E	Elementary/Secondary (0-12)	College (1-4or 2	R	egistered	Nurse		Н	ealthc	are
be filed tral Hygird of other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle,	Maiden Sum	ame)	
should be nd Menta marked	10	Henry Bennetsk	i			Pau1	ine Bana	shki		
os 1 and 2 should be 1 and 2 should be of Health and Ment fittem 27 le marked rother treumatic e	ig.	19a. Informant's Name/Relationship (ng Address (Street					
		Mr. Fred Pankow	/ husband	-	Evergree	n Road,				
rmit. Pages 1 ar partment of Hea portent: If item: y injury or other		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □			natory or other plac	1		20c. Location	n - City or To	wn, State
it. Partimer rtent rtent		' 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer		The second secon	ke Cremat		1			le, MD
permit. Pages Department of the Importent: If ite any injury or of		23a. Part. Enter the disease, or control of the state of	mking 100	363	2. Name and Addres	cond Ave	SW, G1	en Bur		Home, P.A D 21061
cate be executed /Medica physician and the burial-transit	1	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	s a consequence of): s a consequence of):	TOMA 1	MULTER	ORME.			Interval Between Onset and Death 5 MUN Y fi
the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 € No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			1	Date of deliver	y Day Year
quires that n signed b	by	Part II. Other significant conditions of	ontributing to death I	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did tot	_/	•	cause of death?
sicien: The law requires that certificate has been signed b rector, page 2 should be deta	Completed						24a. Was a autops perform	V	. Were autop prior to com death? 1 \(\sum \) Yes \(^2\)	sy findings available pletion of cause of 2 No
Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho		th Check only on			
ding Phys	tion: To	1 Yes 2 No 27. Many or of Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of Inju		28c. Injury Work	4 □ Nursing n	ome 5 Preside 28d. Describe ho			
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, farm, str tc. (Specify)		.00 2	28f. Location (St. City or Town	reet and Nun i, State)	nber or Rural	Route Number,
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best niner: On the basis of and manner st	of my knowledge, death of examination and/or invated.	occurred at the time restigation, in my op	e, date and place binion, death occu	, and due to the ca rred at the time, da	ause(s) and nate and place	nanner as sta , and due to t	ted. the cause(s)
vithii To th	Me	29b. Signature and title of certifier	0 1		29c. License	number	25	9d. Date sign	ed (Month, D	ay, Year)
		10 ambar 8	Buckle	emn	02	2114	7	narch	7,20	05
10		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print) DAMS	FAN E,	BERCEE	SS M	٥	
10		5411 OLD PR	ROERLIK	ED, SUL	FEIS, B	FITIMO.	RE MA	RYLAND	1 4/2	29
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32Registr	rar's Signature	de		•			

State of Maryland / Department of Health and Mental Hygiene 0 5 07690 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 04 0221 M 3 2005 Kobert 0 Parsons /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours to to the second of the secon Yrs. 81 185-14-8979 29, 1923Pennsylvania Director Usuel Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location rel', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Crownsville Maryland Anne Arundel Direct 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number with 823 Old Herald Harbor Road 21032 United States death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Q/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1943-TXXYes 2 □ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 1946 Specify: White 3√Widowed 4 □ Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Heath and Mental Hygiene. Item 27 is marked other than "natured other traumatic event, the Manical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Henry Parsons Jennie Marie Havener 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janice Scheffler / Daughter 458 Arrowhead Lane Breinigsville, PA 18031 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete March 5, 20a. Method of Disposition permit. Pages Department of Important: If it eny injury or o 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) tment of 2005 Catonsville, Maryland Metro Crematory 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one passe on each line. Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complication shock, or heart failure. List only one car Arterioscholic Immediate Cause (Final disease or condition Cardiovasulu disease **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Humminson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its assets.) Due to (or as a sequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Box 68760. physicien Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year ō 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 1 Yes 2 \ No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending To the Huspins after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D50109 MO 3/04/2005 30. Name and address of person who combleted cause of death (Item 23a) (Type, Print) ble punci 7845 Oakwed Road Michael Downing Supe 200 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State MAR 08 2005 Registrar

		1 - For State Registrar		State of	Maryla		artment of F rtificate of		Mental Hy	ygiene Reg. No. 🤈 (205	0760
Physic /Med		1. Decedent's Name (First SUZANNE JAN	,	LIAN					2. Date of D Month MARCH	eath Day	∫ 	3. Time of Death
Exami		4a. Facility Name (If not in:			ber)		4b. City, Town, o	r Location of Dea		4c. Cou	nty of Death	1
Funeral Director		5. Social Security Number 156.46.9588		M 2 T F	7. Age (In yr. 53	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		irth la <i>y, Year)</i>	9. Birth	nplace (State or Fore Intry) N.J
faryland ehow	or		County		10c. (City, Town or Lo	cation					10d. Inside City Limi
death with the Maryland ms 23a or 28e-1 ehow	Director	10e. Street and Number	ONTGOME	CRY		SILVER :	10f. Zip Code			10g. Citizen o	of What Cou	1 □ Yes 2 □ N XX Intry?
d within 72 hours after death with the Marylan giene. or then "natural", or items 23a or 28e-1 ehow the Medical Eraminer must be notified at	ed by Funeral	10410 HAYE 11. Marital Status 1 Never Married X 3 Widowed 4 Di	X Married vorced	2. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? XXNo		Vas Decedent of H f Yes, specify Cuba □ Yes 2 □ No XX	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	o- 14. R		ican Indian, , etc.
e filed within 72 il Hygiene. other then "nal	Completed	(Specify only Elementary/Secondary (College (1-4	4or 5+)	(Give life. L	lent's Usual Occup kind of work done of OO NOT use retired OL TEACHE	during most of wo			ATION	ŕ
Menta Menta arked	To Be	JOSEPH A.	DUNN			_		GERALD	me (First, Middle	AST	ŕ	
s 1 and 2 short If Health and Item 27 Is m other treum	١.	19a. Informant's Name/Re ROBERT PAI		ee, Print)		1041	g Address (Street a		ER SPRII	NG MD 2	0902	
8 = 5		20a. Method of Disposition 1 Burial 2 Crem 4 Donation 5 Ot	her (Specify)		ate MC	Place of Dispose cemetery, crem NMOUTH	sition (Name of natory or other place MEM PK	3.8	Date 3.05	20c. Location		
permit. Pac Department Importent: eny injury o			ORY FI	NK M	101148	MA	Name and Address RYLAND MO	ORTUAŔY	TEN DIED	IIE. MD	21061	
Physician /Medical	8 R	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	List only one			PERFORA	TED COLOR	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions	b.			CUTANEO	US ULCER					
tificate be executed ig physician and as the burial-transit	al Examiner	Sequentially list conditions large teach growth and last cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or	as a conse	SEPTIC quence of):	SHOCH	_				
The law requires that the death certificate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnain the past 12 menths: 1 □ Yes 2 ☑ No 9 □ Unknown	111	c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow	h 2∏Fet ntattime of	al death 3 🗌	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
equires that en signed by ould be deta	by	Part II. Other significant co	onditions cont	ributing to deat	th but not re	sulting in the un	derlying cause give	ın in Part I.		obacco use cor res 2 \(\text{\$\tex{\$\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\texitt{\$\text{\$\texi\\$\$\exititit{\$\text{\$\texitt{\$\text{\$\text{\$\text{\$\texit{\$\text{\$\texit{\$\text{\$\tex	ntribute to th	ne cause of death?
The lar	Completed										prior to cor death?	psy findings available inpletion of cause of 2 No
ing Phys Viter this uneral di	atlon; To Be			spital: 1 Inp. 28a. Date of I		ER/Outpatient 28b. Time of Injury	3 DOA Othe	r: 4 □ Nursing H	ath <i>(Check only o</i> lome 5 Residence Page 1986). Describe h	dence 6 Ot		()
tel or Attences after deather by Director; ed in by the	Certification;	3 ☐ Suicide 6 ☐ C	Could not be etermined	28e. Place of building,	Injury - At h , etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (S City or Ton	Street and Num vn, State)	ber or Rura	l Route Number,
To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fu	Medical	one)	dicar Examine	cien: To the be or: On the basis and manner	s or examina	owledge, death ation and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the o	cause(s) and m date and place,	anner as st	ated. the cause(s)
To To	2	29b. Signature and title of o	1. 2	Sta	w)		29c. License	number 546 Y.		29d. Date signe	ed (Month, L	Day, Year)
.70		30. Name and address of pe ERIC ORIS	TIAN, M	D HOLY	CROSS	HOSPIT	rint) CAL SILVE	R SPRING	G, MD	/ '		
Sta Registr		MAR 0 8 2		32. Regi	istrar's Signa	Conta	•					

Cindy Lynn Reick 05-01647 RJ

	unpend item#23a,27, perris, 6342, State of Maryland / Dep 1- State Registrar Ce	artment of Health and Natificate of Death	fental Hygie	2000 11/69
Physician /Medical	1. Decedent's Name (First, Middle, Last) Cindy Lynn Reick		2. Date of Death Month March 5	 _
Examiner	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Bel Air If Under 1 Year If Under 24 Hrs.	8 Date of Righ	4c. County of Death Harford County
Funeral Director	219 98 6023 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 11,	1970 Maryland
or 28e-f show	10a. State 10b. County 10c. City, Town or L Maryland Harford Edgewo 10e. Street and Number		10a.	10d. Inside City Limit 1 ☐ Yes 2√☐ N Citizen of What Country?
or Items 23a	2312 Rosewood Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21040 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		USA 14. Race - American Indian, Black, White, etc. Specify: White
iled within 72 hours of the then "neturel", cher then "neturel", cher then "neturel", conficial Exert Completed by	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5-)	dent's Usual Occupation skind of work done during most of work DO NOT use retired) 1 Bus Attendant		altimore, County
should be fill marked off umarked off umarked off umartic even	James R. Schroeder	Leatrice	H. Foy	,
permit. Pages 1 and 2 Bepartment of Health a mportent: If Item 27 te nny injury or other tre once.	20a. Method of Disposition 1	Rosewood Drive Edgestion (Name of matory or other place) Cemetery 3/9/2	Date 200	1.21040 :: Location - City or Town, State ynn Oak, Maryland
permit. P Departme Importen any injur	21. Signature di Funeral Service Licensee	2. Name and Address of Facility ruzdzinski Funeral 407 Old Fastern Ay	Home P.A	4.
Cate be executed hysician and the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit	23a. Pag1. Enter the disease, or complications that caused the death. Do not enspoke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
death certific e attending p d for use as		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
es ti gne be d	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Modelmow
	25. Was case referred to medical		24a. Was an autopsy performed Yes 2	
After this funeral dis	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury At home, farm, st	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	a 6 □Other (Specify) njury occurred t and Number or Rural Route Number.
To the Hospitel or Attent within 24 hours after death within 24 hours after death of the Funerel Director: completely filled in by the Medical Certifical	29a. Cartifier (Check only 2X Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place,	City or Town, Si	tate) e(s) and manner as stated.
within 2-	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed caus death (Item 23a) (Type	29c. License number OCME	29d.	Date signed (Month, Day, Year) March 6, 2005 Dre, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) MAR 0 8 2005 MAR 0 8 2005		c partill	ore, marytand 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [5] PER PHY C841 3 68 Hisate of Death 2. Date of Death 3. Time of Death DAWN E. RUIKOWSKI-MARSIGLIA Month y Physician 12:01 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore fospita audall Tirun Northwest enles 8. Date of Birth (Month, Day, Year) June 17,1964 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 👿 F Months Days Hours 213-92-1827 40 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State and Montair Hygiene.
Is marked othar than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Bel Air Director Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 1300 Delphi Court U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nutritionist traumatic avent. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Esther Kulczynski Rutkowski, Sr. J. Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5508 Dunrovin Lane, Perry Hall, MD 21128 Health at tem 27 l Mrs. Esther Rutkowski (mother) item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem'l 03/07/05 Timonium, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 Dum a Wel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed ARDS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ESPLO 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 NO To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Diractor: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who complet d cause of death (Item 23a) (Type, Print) IMPERIAL N 111097

DHMH 17 Rev 1/2001

State

Registra

31. Date filed (Month, Day, Year) MAR 0 8

32 Registrar's Signature

2005

		-	For Stata Registrar	State of Maryland		rtment of He tificate of D			iene eg. N2 0 0 5	07694
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) George Rodriquez	Davila aka	a Jor	ge Rodri	iguez	2. Date of Death	04 2005 ear	3. Time of Death 1450 M
	Examin		4a. Facility Name (<i>If not institution, give</i> s Washington Advent			4b. City, Town, or Takoma	Location of Death		4c. County of Dea Mont go	
	Funeral Director		5. Social Security Number 6. Sex 620-01-2708 №	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		thplace (State or Foreign Lintry) Icaragea
	aryland show	2	Usual Residence of Decedent 10a. State 10b. County MD Mont gome		Town or Loo		·-			10d. Inside City Limits 1 ☐ Yes 2X No
	with the M a or 28a-f be notifie	Director	10e. Street and Number 525 Thayer Ave #11		ver of	10f. Zip Code 20910		11	0g. Citizen of What Co	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heathl and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28a-f show any figury or other treumatic event. The Madical Examiner must be notified at an once.	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 Yes MYNo If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify: Nica		14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	within 72 hou ene. then "netural he Modical E	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life. [ent's Usual Occupa kind of work done d OO NOT use retired) Intenance		ng	16b. Kind of Business	
and 2	id be filed ental Hygi ked other c event, I	To Be Co	17. Father's Name (First, Middle, Last) George Graldo Rodr	iquez			18. Mother's Name			
Mary	nd 2 shou Ith and M 27 is mari	F	19a. Informant's Name/Relationship (Type Concepcion Rodrique		19b. Mailin 525 T	g Address (Street a hayer Ave	nd Number or Rura e #114 Si	l Route Number, 1ver Spi	City or Town, State,	Zip Code) 910
Baltimore,	Pages 1 ar ment of Hea ant: If item: ury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	metery, crem	sition (Name of natory or other place , Nicara	3/14	4/05	20c. Location - City or Managua Nicaragea	Town, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	Hellan						
	Pnysician /Medical	8 0 Pa	29a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	deal	er the mode of dying	s such as cardiac o	er respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any leading to immediate	Due to (or as a conseque			/			4
8760,	cate be executed physicien and the burial-transit	dicai Examiner	If any leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
O. Box 68	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnan 1 ☐Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	sign sign d be	by	Part II. Other significant conditions earn	tribating to death but not resul	ting in the ur	elerlying cause give	n in Part I.		pacco use contribute to	
al Records,	The law ate has b page 2 sl	Completed	0						y prior to death? □ St No 1 □ Yes	utopsy findings available completion of cause of
of Vital	Phys this al dii	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of		P/Outpatien	The same of the sa	4 Nursing no	me 5 Reside	e) once 6 Other (Special Course)	ocify)
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeret Director: After completely filled in by the funer	Certification;	1 Ural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify)	Injury		′es 2 □No		reet and Number or R	ural Route Number,
_	e Hospitel 24 hours a e Funeret l etely filled	ledical C	29a. Certifier 1 ★ Certifying Phys	sicien: To the best of my know her: On the basis of examination	rledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place, a inion, death occurr	and due to the ca	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number / 1/, 7	25	9d. Date signed (Mon	th. Day, Year)
	10		30. Name and address of person who co Nasreen Kango 761				0 / 7 / D 20912		3/1/0	ı
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 8 2005	2. Registrar's Signatu	ure Car	Ð				

		_		artment of Health and M rtificate of Death	lental Hygie	4000	07695							
ı	Physici		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Donald Monroe Rickerson		2. Date of Death Month 03 0	Day 2005	3. Time of Death 7:15a M							
ı	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1							
	Funeval		Washington Adventist 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Takoma Park If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom	ery place (State or Foreign							
l.	Funeral Director		500-20-3964 X⊠M 2□F 81 Yrs.	Months Days Hours Min.	8. Date of Birth	924 SN	ew Jersey							
	nyland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits							
	the Ma 28a-1 s	ector	MD Montgomery Silver S	Spring 10f. Zip Code	100	Citizen of What Cou	1 ☐ Yes ¾ANo							
	th with 23a or	al Dir	14613 Notley Rd	20905	109.	USA	and y ?							
5-0036	be filed within 72 hours atter death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madiral Examinar must be notified at	by Funeral Director	1 □ Never Married 28©3Married 13© Yes 2 □ No 1945	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W								
-c -c	"natur	leted	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workind DO NOT use retired)	ng 16b	. Kind of Business/li	ndustry							
212	d withir giene. er than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	gineer	Na	ational Se	ecurity							
Maryland 2121	be de la de	To Be (17. Father's Name (First, Middle, Last) Karel Rickerson	Helen (
	s 1 and 2 should of Health and Mer item 27 is marke other treumatic			ng Address <i>(Street and N</i> um <i>ber or Rur</i> a .3 Notley Rd. Silve			p Code)							
Baltimore,	Pages 1 and 2 nent of Health out: If Item 27 ary or other tra		20a. Method of Disposition 1 Burial 25 Fremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 03-08-2005 Beltsville M											
Balt	permit. Pages. Department of I importent: If ite eny injury or of once.		21. Signature of Funeral Service Ligens	R. Name and Address of Facility Rapp Funeral & Cren 1933 Gist Ave Silven	mation Ser r Spring N	rvices MD 20910								
į	Physician /Medical Examiner		Due to (or as a consequence of):	ter the mode of dying, such as cardiac o			Approximate Interval Between Onset and Death							
/09/	ate be executed obysician and the burial-transit	dical Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
.O. Box 68	ath certific attending p for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	rery Day Year							
rds, P.	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?							
Vital Records,		e Completed	Dementia Consulty Antery Disen 25. Was case referred to medical	-Sc	24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of							
Divisi	ei or Attending Ph s after death. i Director: After th id in by the funeral	Sertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rur tate)	al Route Number,							
	To the Hospitel or Att within 24 hours after do To the Funerel Direct completely filled in by t	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl and one one one one one one one one one one	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)							
	To ti withii To ti comp	M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	7 20 US							
	20H		30. Name and address of person who completed cause of death (Item 23a) (Type, Pamela Mulshine 10801 Lockwood Dr.	· ·	≥ MD 2090	1	i							
	Sta Registr	-	Pamela Mulshine 10801 Lockwood Dr. #205 Silver Spring MD 20901 31. Date filed (Month, Day, Year) Registrar's Signature											

			For State Registrar	State of Ma		epartment of Certificate of			2005	07696
	Dhysioi	210	1. Decedent's Name (First, Middle, La	st)	-			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic			en Lorrain	e Ruby			MARCH 3		5:45a [™]
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Death	
			Gilchrist Cente 5. Social Security Number 6. S		(In yrs. last birth	TOWSO		9 Date of Birth	Baltimo	
	Funeral Director		220-18-8055	1 M 2	78 Yr	Months Days		8. Date of Birth (Month, Day, Y) DEC 23,	1926 Mar	place (State or Foreign intry) Cyland
	tand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			-	10d. Inside City Limits
	Mary First	to	Maryland N/A			Ra1	timore			1 DXYes 2 □ No
	h the or 28s	irec	10e. Street and Number			10f. Zip Code	CINOLC	10g	J. Citizen of What Cou	intry?
	th wil	aiD	3914 Chesley A	venue			21206		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23e or 28a-f show any injury or other traumatic event, It a Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
9	2 hou	ted	15. Decedent's E	ducation	16a. D	ecedent's Usual Occu	pation	. 16	b. Kind of Business/Ir	ndustry
21215-0036	ne. han "r	Completed	(Specify only highest gr	College (1-4or 5	+)	Give kind of work done ife. DO NOT use retir	ed) ed)	ang		
15	should be filed within nd Mental Hygiene. marked other than " imatic event, II.e Max		17. Father's Name (First, Middle, Last)		Homemaker	19 Mather's Nam	e (First, Middle, Ma	Domesti	C
an	d be l	o Be	Elmer Penne					lie Vermi		
Maryland	should be nd Mental marked c	ဥ	19a. Informant's Name/Relationship	Type, Print)	19b. N	failing Address (Stree			City or Town, State, Zi	p Code)
	and 2 salth a n 27 Is		Odie Lee Easton/	son					e, MD 2120	
ore,	of He		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □		20b. Place of D	Disposition (Name of crematory or other pl		Date 20	c. Location - City or T	own, State
Ĕ	Pages nent of ant: If It ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci			Crematory,		/05	Baltimo	ore, MD
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Lice homo S Thomas Gr.	Duga		Cremation	Society (of Maryla	nd, Inc.	
	-		23a. Part1. Enter the disease, or con shock, or heart failure. List only		the death. Do no	t enter the mode of dy	rick Road	or respiratory arrest	re, MD 212	Approximate
	Physician		Immediate Cause (Final disease or condition	One cause on each in		ive Lu	ng dis	ease		Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a consequence of		-			7.00
ď	Examiner		Sequentially list conditions.	b						
T	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):				
V .	xecut and	хап	that initiated events resulting in death) Last	cDue to (or as	a consequence of	<u> </u>				
68760,	ficate be executed physician and is the burial-transit	edicai E	(_ d						
_			IF FEMALE:							
P.O. Box	Physician: The law requires that the death certif r this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death	3 ☐ Ectopic pregnants ☐ Other (specify)	су		23d. Date of deliv Month	rery Day Year
	that bed by deta	by Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in t	he underlying cause g	iven in Part I.	23e. Did tobac	cco use contribute to t	the cause of death?
rds	w requires been sign should be	ed b	probable	Acute	strole	e		1 Yes	2 ☐ No 3 ☐ Pro	bably 4 🗆 Unknown
Division of Vital Records,	sician: The law re certificate has bee irector, page 2 sho	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
<u>Fa</u>	in: Ti ificate or, pa	e Co	25. Was case referred to medical				00 Diana d Daniel	1 Yes 2		2 No
>	ysicia s cert directi	0 8	examiner?	Hospital:	nt 2 ☐ ER/Outp	atient 3 DOA		h <i>(Check only one)</i> ome 5 ☐ Residenc	se 6 (A) ther (Speci	MA - 112
0	g Phys er this eral dir	n: T	27. Manner of Death	28a. Date of Injur (Month, Day	y. 28b. Tir	ne of 28c. Inju		28d. Describe how		WE TO STORE
ior	ttending I death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation	n	(Ye <i>ar)</i> Inj		Yes 2 □ No			
Divis	al or Attenos after death	Certification;	3 Suicide 6 Could not be determined			n, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination and/	death occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	1 - 1.	6		se number		Date signed (Month,	
7	1		30. Nam and ddress of person who	complet d cause of de	eath (It 23a) (T	ypa, Print)	12C. C	2-04	MANCh 3	,200
	9 Sta	to	31. Date filed (MARPany 8r) 20	7 (-)M DE . Registra	() 6/0	1 14-6-6	57,	70016	1019 5	1204
	Registr		MIAN V Q ZB	He party les	ar's Signature					

Helen Ruby 3-3-05 c.S. 45Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10c per fn 8841 3-8-05 vt. State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death REE() BEATRICE Month Day Zeos 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MANDAMS TOWN SUBACUTE AT NORTHWEST BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Dec 12/1933 Mecklinburg 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2QF 216-30-0439 71 Yrs Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Randalistown Randallstown 1X Yes 2 No Ba]timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8908 Liberty Rd. 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: Black 3€ Widowed 4 □ Divorced 15. Decedent's Education (Specify onfy highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Unk. Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alonzo McClelland Cora Inez Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Williams (daughter) 8908 Liberty Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 Donation 5 ☐ Other (Specify) School 1/28/05 Washington,DC Production No. 1/28/05 Washington,DC 20011 Howard Med. 21. Signature of Funeral Service Licensee . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or freart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ESOPHAGEAL CARCINOMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate autority of the cause (Disease or injury that initiated events resulting in death) Last b Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? ueatn? 1 ☐ Yes 2 No 1 Yes 2VZ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Voluming Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Actural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

TANY AM

26,2005

Ph sician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. of Vital Records, Division within 24 hours a To the Funaral C completely filled i

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

28a-f show

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Itams 23a

Director

Completed by Funeral

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Physician/Medicai Examiner

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Completed

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Certification: To

Medicai

29a, Certifier

(Check only one)

29b. Signature and title of certifier

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page 2 should

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other traumatic event. The Medical Examiner must be notified at

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Department of Important: If any injury or once.

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Itams 23s

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NECL MO LAVI SALTO 31. Date filed (Month, Pay

32. Registrar's Signature

ORIGINAL

		1_ For State	State of Maryland / Dep		ealth and M	ental Hyg	giene	0760
		Registrar		runcate of L	Jeain		Reg. No.	0/69
Physic	ian	Decedent's Name (First, Middle, Last		Dath		2. Date of Dea	Day 200 Year	3. Time of Death
/Med	cal			Roth		March		
Exami	ner	4a. Facility Name (If not institution, give			Location of Death		4c. County of De	
		Holy Cross Hosp		Silver S			Montgome	
Funeral Director		5. Social Security Number 6. S. 510-14-8496 1 Usual Residence of Decedent	7. Age (In yrs. last birthday 82 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day July 15	9. Bi 3, 1922 Kar	rthplace (State or Forei country) 1535
land ow		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limit
Many -1 sh	ğ	Maryland Montgome	erv Silver	Spring				1 ☐ Yes 2 🔯 N
the 28e	ec	10e. Street and Number	511.01	10f. Zip Code			10g. Citizen of What C	Country?
with Ba or	0	117 Claybrook Dr	ive	209) n 2		United St.	*
eeth	era	11. Marital Status				offy Vac or No		
lten Iten	ä	1 Never Married 2 Married	Armed Forces?	Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puerto f	Rican, etc.)	Black, Wh	
rs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2🗓 No	Specify:		Specify: W	hite
within 72 hours after deeth with the Maryland ane. than "neturel, or items 23a or 28e-f show he Wedteal Examinar must be notified at	Completed by Funeral Director	15. Decedent's Ed		edent's Usual Occupa	ation		16b. Kind of Busines	Andustri
in 72 i "ne ledis	Siet	(Specify only highest gra	de completed) (Give	e kind of work done d DO NOT use retired,	furing most of workir	ng	Securities	
with ene. ther	E E	Elementary/Secondary (0-12)	College (1-4or 5+)	retary	,		Commission	
be filed within 72 hours after deeth with the Marylan ital Hygiene. Id other than "neturel", or items 23a or 28e-f show event, the Medical Examinat must be notified at		17. Father's Name (First, Middle, Last)			18. Mother's Name			
d be antal	Be C	Frank P. Roth			Sophia E			
should be and Mental s marked o	2	19a. Informant's Name/Relationship (ima Printi	ing Addross (Street a			r, City or Town, State,	7.0.4.1
		Andrew J. Weiss /						
1 and 2 Health tem 27		20a. Method of Disposition	20b. Place of Disp				nantown, M 20c. Location - City o	
iges if it		1 ☐ Burial 2 X Cremation 3 ☐	Removal from State cemetery, cre	matory or other place	1101011			
tmer tent tent		'4 □ Donation 5 □ Other (Specify		Crematorium,			Bethesda,	
permit. Pages : Department of H Importent: If ite any injury or ot		21. Signature of Funeral Services Licen	/ ROLLOGE RO	2. Name and Addres bert A. Pum 00 West Mont	s of Facility phrey Funer gomery Aven	al Home/I ue, Rock	Rockville, I	nc. and 20850-280
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ilications that caused the death. Do not en	iter the mode of dying	g, such as cardiac or	respiratory arr	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	. 33					Days
/Medical		resulting in death)	a. Sepsis Due to (or as a consequence of):					
Examiner			Urinary Tract I	nfection				Days
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	Due to (or as a consequence of):					Days
uted d ansit	Examiner	Cause (Disease of injury that initiated events						
exec in an	Exa	resulting in death) Last	Due to (or as a consequence of):			-		
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai		d					
leath certificat attending phy I for use as the								
ndin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of de	livery
death a atte d for	cia	in the past 12 months? 1 □ Yes 2 ☒ No	4☐Pregnant at time of death 5{	□Ectopic pregnancy □ Other (specify)			Month	Day Year
that the de led by the detached	nys	9 □ Unknown	9□ Unknown					
that	by Pl	Part II. Other significant conditions of	entributing to death but not resulting in the u	underlying cause give	n in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
uires sign	Q D	Mitral Valve Rep	lacement			1 □ Ye	es 2□No 3□P	robably 4 \text{\text{Unknow}}
w require been si should t	lete	Aortic Valve Rep	lacement			24a. Wasa	24h Wass s	. As a second control of the second control
has has	Completed					autops perforr	y prior to	utopsy findings available completion of cause of
		Atrial Fibrillat	lon			1 ☐ Yes		2 □ No
Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Otho	26. Place of Death		**	
Phys this at dii	L 2	1 182 5 5 140	inpatient 2 ER/Outpatie		4 Nursing non		ence 6 Other (Spe	ocify)
fe fe	on	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work'	?	8d. Describe no	ow injury occurred	
Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			'es 2 □ No			
or At fter of freci	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	2	8f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
urs a		MERCHANICA WE TO THE						
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	dical	29a. Certifier (Check only one) 1 ☒ Certifying Physical Example one)	vsician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	th occurred at the time exestigation, in my opi	e, date and place, a inion, death occurre	nd due to the ca d at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
oth oth omp	₹ Ø	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Moni	h, Day, Year)
C > F 0		> Whoma	Mh-	עצי.	2332	1	March 1 2	005
, /		1	ompleted cause of death (Item 23a) (Type,		٠٠٠٨		March 1, 2	COO
15		S. K. Gupta, M.D.	9801 Georgia Aven	•	Silver Si	orino l	Marvland 2	0902
1		31. Date filed (Month, Day, Year)	32. Registrar's Signature	# .	DITAGE D	br Tite 1	Talyland 2	0,02
St Regist	atė rar	MAR 0 8 2005	Bar A Ages					

RIBE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. UU 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** March 3, 8:00 AM Margaret Μ. Rigney 2005 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Multicare Center Baltimore N/A If Under 24 Hrs. 5. Social Security Number $212\ 05\ 1683$ 6. Sex 7. Age (In yrs. last birthday) 95 vrs 8. Date of Birth
Jan. 27, 1910

9. Birthplece (State or Foreign
County)
Mary Tand **Funeral** Days Months Hours 1□ M 2∑X Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mantel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1, Yes 2 □ No Funeral Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Keswick Multicare 700 W. 40th Street 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√TXNo Specify: Specify: White ģ 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Miller Cora Zepp 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Mann Daughter PO Box 66 Uniondale, IN 46791 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Ball Timore Washington 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 3/7/2005 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematory 22 Name and Address of Fecility Burgee-Henss- Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 21. Sign Juye of Funeral Service Licensee Š 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) neum anw Examiner Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last attending physician end for use es the bunel-trar Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medical Certification: To 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Diractor: After complately filled in by the funer 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature end title of certifie 30. Name end address of person who completed of death (Item 23e) (Type, Print) COMMIC 6701 31. Dete filed (Month) Pay strar's Signature 32. P State Registrar

			For State Registrar	State of	Maryland	•	artment of l				gien e Reg. No.	005	07700
	Physicia	an	Decedent's Name (First, Mi	Anne Eliz	aheth f	Robins	son			2. Date of De. Month	ath Day	Year 7, 2005	3. Time of Death 7:45 p. M
	/Medic		4a. Fecility Name (If not institu			tobilit	4b. City, Town,	or Location	of Death	1 001		County of Death	
	Examin	er		Gilchrist Hospi					Balti	imore		Baltin	nore City
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. I		If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birth	place (State or Foreign intry)
	Director		212-03-8922	1□M 2XF	89	Yrs.				March 14	4, 1915	5	Maryland —
	and		Usual Residence of Decedent 10a. State 10b. Cou	nty	10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Maryi f sho	tor	Mandand	Howard				Columb	ia				1 ☐ Yes 2 No
	death with the Maryland ims 23a or 28a-f show	Director	Maryland 10e. Street and Number	Howard			10f. Zip Code	Oolullio			10g. Citiz	zen of What Cou	untry?
	h with		6692 Cedar Lane						044			U.S	S.A.
	72 hours after death with the Marylar "netural", or Itams 23e or 28e-f show refical Examiner must by rediffed at	Funeral	11. Marital Status		dent Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic C ban, Mexic	rigin? (Spean, Puerto	ecify Yes or No Rican, etc.))- 1	 Race - Amer Black, White 	
99	72 hours after netural', or Ita dical Examina	by Fu	1 Never Married 2 Never Marri	If Yes Give	9		1□ Yes 2 No					Specify:	White
Ö	hours tural'	d b		dent's Education	ites:	16a Dece	dent's Usual Occi	pation			16b. Kir	nd of Business/I	
7	in 72 " net	Completed	(Specify only hi	ghest grade completed)	40.5.\	(Give	kind of work don- DO NOT use retir	e <i>during mo</i>	st of worki	ing		Cle	erical
212	filed within Hygiene. Ither then "	mo	Elementary/Secondary (0-1	2) College (1-	-401 5+)			Secretar	у				
٦	e filed at Hyg otha	BeC	17. Father's Name (First, Mid	dle, Last)				18. Mot	her's Name	e (First, Middle	, Maiden	Sumame)	
<u>a</u>	Ments Ments arked	To		Eugene Short								ddinger	
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 Is marked othar than " treumatic avant, the Med		19a. Informant's Name/Relat	onship (Type, Print)			ng Address (Stree					r Town, State, Z	ip Code)
	jes 1 and 2 should be filed within 72 hours after death with the Maryla of Heath and Mental Hygiene. If itam 27 is marked other than "netural", or Itams 23a or 28a-t show if itam 27 is marked other than "netural", or Itams 25 or 28a-t show other traumatic avant. It is Medical Examiner in ust be institled at		Mrs. Eileen S	hields Legal	Guardian	lace of Disp	10621 Vista osition (Name of			Maryland :		cation - City or	Fown, State
õ	Pages 'nent of H nnt: If its		1 ☐ Burial 2 ☐ Cremati			emetery, cre	matory`or other pi	lace)	02/	04/2005		Sykocyilla	, Maryland
altimore,	그 든 원 분		'4 □ Donation 5 □ Other 21. Signature of Funeral S	10		1	remation Se	race of Eac	ility	04/2005		•	•
Ba	permi Depa Impo eny ir		Molman	MUNT	MDI29	5	Slack	Funera	l Home	, P.A.			
			23a. Part 1. Saler the disease shock, or heart failure.	or complications that co	aused the deat	h. Do not en	ter the mode of d	Old Col ying, such a	umbia is cardiac	PIKE EIIICO or respiratory a	rrest,	MD 2104∂	Approximate . Interval Between
	Pnysician		IIIIIII Odlate Cause (i iiiai	List only one cause on ea			neven	nia					Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a conseq		· worr.		10				0173
子厅	Examiner		Sequentially list conditions	6. 9Ma	Share	nh	sturing	10	eme	intia			years
IT W	P =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):	7						0
MA	ecute and -trans	Examine	that initiated events resulting in death) Last	c	or as a conseq	uence of):							
100 8760,	ate be executed hysician and the burial-transit		,		,0, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	,							
. 2	ate hy:	dic		d									
×	The law requires that the death certific tae has been signed by the attending page 2 should be detached for use as	hysician/Medical	IF FEMALE: 23b. Was decedent pregnan	23c. If yes, out			□r				2	23d. Date of del	
- 8 W	death e atter	iciai	in the past 12 months?	4☐Pregn	ointh 2 ☐ Feta nant at time of c		□Ectopic pregnar □ Other <i>(specify)</i>					Month	Day Year
0	that the de ed by the a detached	hys	9 Unknown	9□ Unkno									
S, F	w requires that been signed to should be det	by P	Part II. Other significant cor	iditions contributing to de	eath but not res	sulting in the	underlying cause	given in Pai	rt I.		Yes 2		the cause of death?
WWE cords,	equir sen si ould	ted								-			
≶ 5	e lawr has be ge 2 sh	ompleted							<u>_</u>	24a. Was		prior to death?	topsy findings available completion of cause of
		Con								1 ☐ Yes	2. 3 No		2 No
Vits (Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to me examiner?	Henrital		1500		Other		th <i>(Check only</i> ome 5 ☐ Res	TIP.	Other (Spe	w hessen
3 6	Phys r this ral dii	-: To	1 Yes No	1	Inpatient 2 Confiniury th, Day Year)	ER/Outpation 28b. Time	of 28c. In	jury at	Nursing no	28d. Describe		14	carry)
× 6	Attending F r death ector: After by the funer	tion	1 Natural 5 P	ending (Monivestigation	th, Day Year)	Injury		∛ork? ∐Yes 2	□No				
J. W. W.	Atten r dea ector by the	ifica	3 ☐ Suicide 6 ☐ C	ould not be 28e. Place	of Injury - At h	ome, farm, s	treet, factory, offic	ж			(Street an		ural Route Number,
(C) in	s afte s afte al Din	Certification:											
~	To the Hoscital or Attend within 24 hours after death To the Funeral Director: /		29a. Certifier Check only Z Med	tifying Physician: To the	asis of examina	owledge, dea	ath occurred at the investigation, in m	time, date y opinion.	and place, leath occur	, and due to the rred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	ro tha Hivithin 24 Fo the Fisomplete	Aedical	0001	and man	ner stated.			ense numbe	ar		29d Dat	te signed (Mont	h Day Year)
	To To	Σ	29b Signature and title of ce	ertuler (7	220	2		T-1	0.000.7	2 2005
	00			ann	/UU\	m 92a\ /T	Print'	, 0, 0	>		100	moig -	
	, J		30. Name and address of pe	rson who completed cause	- 1 0	m 23a) (Typi	Char	tos s	7 11	within	rex	WO 21	1204
. 1	Si	ate	31. Date filed (Month, Pay, MAR 0 8	Year) 32. F	Registrar's Sign				V				
	Regist		MAR U 8	2005	in B.	Spa	de						

		•	For State Registrar	State of M	aryland / De <i>C</i>	partment of F e <i>rtificate of</i>	Health and I Death		giene 0	05	07701
			1. Decedent's Name (First, Middle,	Last)				2. Date of De		Year	3. Time of Death
	Physici /Medic		RONALD BURNS	ROSS				FEBRUA		2005	10:55 P M
	Examir		4a. Facility Name (If not institution, FREDERICK MEMO	-		4b. City, Town, o FREDER	or Location of Deatl ICK	h		ty of Death ERICK	
H	Funeral Director		5. Social Security Number 055–26–6596	6. Sex 7. Ag 1 X M 2 ☐ F	ge (In yrs. last birthda 87 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th ly, Year) 1917	9. Birthi Cour Cana	
	D.		Usual Residence of Decedent 10a. State 10b. County		10. Cit. T						and the state of the state
	aryla shov	5		lerick	10c. City, Town or	erick					10d. Inside City Limits 1 ☐ Yes 2√ No
	28a-f	Funeral Director	10e. Street and Number		1100	10f. Zip Code			10g. Citizen of	What Cour	
	with with	اق	7351 Willow Roa	.d c 7		101. Zip 000e	01700				nu y r
	ns 23	lera	11. Marital Status	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cub	21702 Hispanic Origin? (S	pecify Yes or No		SA Ice - Ameri	
320	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-1 show event, tre Medical Examinat must be routified at	by Fur	1 ☐ Never Married 2 💢 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' ad 1 Tyes 2 X If Yes, Give Year or Dates:	No	If Yes, specify Cub 1 ☐ Yes 2X No		to Rican, etc.)		^{ack,} White, ify: Whi	
ž	2 hou		15. Decedent		16a. De	cedent's Usual Occup	pation	elein e	16b. Kind of	Business/In	dustry unl
Maryland 21215-0036	filed within 72 Hygiene. other than "nai ent, I've Medic	Completed	(Specify only highes: Elementary/Secondary (0-12)	College (1-4or	5+)	ve kind of work done b. DO NOT use retire administra		rking			
Ö	Hygother other	Be C	17. Father's Name (First, Middle, L	ast)				ne (First, Middle,	, Maiden Suma	me)	
<u>a</u>		To B	William Alex	ander Ross			Mary E	llen Gil	ligan		
ary	and Men is marke	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	ailing Address (Street	and Number or Ru	ural Route Numbe	er, City or Town	n, State, Zip	Code)
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Barbara Ross/da	ughter	15	Nightingal	e- Way #.	A2 Luthe	rville.	200	21093
Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 Cremation 4 X Donation 5 Other (Sp		cometany of	position (Name of rematory or other pla		Date	20c. Location	- City or To	own, State
Balt	permit. Pages Department of I Important: If ite any injury or of		21. Sign that of Funeral Service I RONAL S	Wade, Dir	ctor	22. Name and Addre State Anat altimore,	omy Board	1 655 W.	Baltim	ore S	treet
			23a. Part 1 Enter the disease, or shock or heart failure. List of	complications that cause only one cause op each I	d the death. Do not						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		gestiv	e hear	a Kari	yre			Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	e hear	7	90			X Jay 5
П	Examiner		Sa uentially list conditions,	b	/						/
	sit s	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or):						
_	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of);					-	
8760,	be e										
98	ficate p phys is the	edical		0.							
O. Box	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No □ 9 □ Unknown		2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			ate of deliversionth	ery Day Year -
P.O.	that the sed by detac	Ph	Part II, Other significant conditio	ns contributing to death I	out not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	obacco use cor	ntribute to t	he cause of death?
Records,	uires tha signed d be det	d by	HuperteH	(CV)				1 🗆 '	Yes 2 No	3 Prob	pably 4 Unknown
S	w require been sig should b	Completed	Vi had	es meu	, ,			24a. Was	an 24b	Were auto	psy findings available
Re	he lay e has	ш	_ Olabet	Sileu	1+00		=	autor	osy ormed?/	prior to co death?	mpletion of cause of
Viita		e Cc	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes ath (Check only o	2 No	1 🗆 Yes	2 L No
>	s cert	To B	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ER/Outpa	ient 3 DOA Ott	ner: 4 🗆 Nursing H			her (Specif	·v)
0	g Phys er this eral di	Į,	27. Manner of Death	28a. Date of Inj	ury 28b. Time	of 28c. Inju	ry at	28d. Describe			,,
0	nding lath. r: After e funer	atlo	Natural 5 ☐ Pending 2 ☐ Accident investig		ay rour, injur		Yes 2 □No				
Division of	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of It	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (: City or Tox		ber or Rura	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical !	g Physician: To the best Examiner: On the basis of and manner s	of examination and/o	eath occurred at the training of investigation, in my of	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
	Fo th Within Fo th	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
ł			1	Shah	Hiren	D	51643	3	2/25	105	
			30. Name and address of person	who completed cause of	death (Item 23a) (Ty				1		
_	75.0		65 C Tho	mas T	honson	0	Frede	ick	mo	0170	12
ĺþ.	Sta		31. Date filed (Month, Day, Year)	32, Regist	rar's Signature	V.					
	Regist		MAR 0 8 2	005	N. A.	(1)					
UL	IMH 17 Rev 1/2	UUI		and the same of th							

ORIGINAL

		1 - For State Registrar	State o	f Maryland	-		t of Healt e of Dea		Mental Hy	giene	2005	0.7	702
		1. Decedent's Name (First, Middle, La.	st)						2. Date of De			3. Time	of Death
Physic /Med		Ruth E. Shaffer							Month Mar	Day 7	/ Year 2005	12	ΔΜ
Exami		4a. Fecility Name (If not institution, giv	e street and nu	mber)		4b. City,	Town, or Local	ion of Death		4c.	County of Dea	th	
		Mariner Health of	Catons	ville		Cator	nsville			I	Baltimo:	re	
Funera	1	5. Social Security Number 6. S		7. Age (In yrs. I		If Under Months	1 Year If Ur Days Hou	nder 24 Hrs.	8. Date of Bi	rth	9. Bir	thplace (State	e or Foreign
Director	r	213-22-6808	☐ M 2 🗗 F	93	Yrs.				July 9	, 19	ll Mar	yland	
pur *		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	cation						10d. Inside	City Limits
sho	5				imore	oation							es 2 🔀 No
the N	Director	10e. Street and Number		Dail	Illore	10f. Zip	Codo			10a Cit	izen of What C		
with	급	309 Clays Lane				2124				-	ed Sta		
eath	Funeral	11. Marital Status	12 Was Dec	edent Ever in U.	S 13 1			Origin2 (S	pecify Yes or No	-	14. Race - Ame		
iter d	E G	1 Never Married 2 Married	Armed Fo	orces?		f Yes, spec	rfy Cuban, Me	kican, Puert	o Rican, etc.)		Black, Whi		
urs a	2	3 ☑ Widowed 4 ☐ Divorced	If Yes, Gr Year or D	ve		1 ☐ Yes 2	No Spe	cify:			Specify: V	<i>l</i> hite	
2 ho	Completed	15. Decedent's E			16a. Dece	dent's Usua	Occupation	mant of wor	dein a	16b. K	ind of Business	/Industry	
Pin 7	l e	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT us	k doné during e retired)	most of wor	KING				
Agien Agien erth	ő	8th			Home M	laker				Her	Home		
tal Hy	Be	17. Father's Name (First, Middle, Last,	l				18. N	lother's Nan	ne (First, Middle	, Maiden	Sumame)		
Meni Meni arke	P								th Ebert				
inc, Midily idea (L. 12.10.00) s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, it e Madical Extrainment must be notified at		19a. Informant's Name/Relationship (Type, Print)			-	•		ral Route Numb			Zip Code)	
and and lealth m 27 m 27 her tu		Donald Shaffer (so	n)	OOK DI	5921 lace of Dispo	Kenne	tt Pik	e Wil	Lmingtor				
Pages 1 and nent of Health nt: If item 27 iry or other tr		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from	State	emetery, crer	natory or of	ther place)		Date		ocation - City or		
tant:		* 4 □ Donation 5 □ Other (Specif		Lor	raine						imore, 1		
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai	ġ	21. Signature of Funeral Service Licer	ISEE	7	Bu	. Name and Irrier	d Address of F -Queen	Fune:	al Home	& Cr	ematory	, P.A.	
40260		College Control	Co		12	.12 W.	ота г	iberty	7 Ka. Wi	nfie	ld, MD	21/84	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on e	each line.		1		n as cardiad	or respiratory a	irrest,		Approxim Interval B Onset an	etween
Physician /Medical	_	Immediate Cause (Final disease or condition resulting in death)	a		2 ~~	me	2					4	7c
Examiner			Due to	(or as a consequ	ience of):								
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	ience of):								
uted	뒽	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									(1		
exection and ital-tra	Examiner	resulting in death) Last	Due to	(or as a consequ	ience of):								
icate be executed physician and sthe burial-transit	dical		_d										
tifica ng ph as th	0												
th cer endir r use	N/ug	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnat		Ectopic pre	egnancy			1 :	23d. Date of de		
dea he att	SC	in the past 12 months? 1 □ Yes 2 □ No		nant at time of de		Other (spe					Month	Day	Year
w requires that the death certific been signed by the attending f should be detached for use as	Physician/M	9 Unknown			M' '- M				00- Did		rse contribute to	Albanas	6 de-160
res th	à	Fattii, Other significant conditions of	ontributing to a	eath but not result	iking in the u	nderlying ca	ause given in r	'аπ ι.		Yes 2			Death?
neen s	ted			AJan)						193 21		ODADIY 4	POLIKIOWI .
a law	ompleted								24a. Was	DSV	24b. Were at	itopsy finding completion of	s available cause of
The cate	ပို								1 Yes	2 D No	death? 1 ☐ Yes	2□ No	
vician: The lav certificate has	Be	25. Was case referred to medical examiner?	Hospital:				Other		th (Check only				
Phys this	2	1 Yes 2 No 27. Manner of Death	. 10		ER/Outpatien		A 40	Nursing H	ome 5 Resi			city)	
After funer	0	1 Natural 5 Pending		th, Day Year)	28b. Time of Injury	M	8c. Injury at Work? 1 ☐ Yes	2 IT No	200. Describe	now injul	y occurred		
death death the	icat	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At ho	me farm str	-		2 140	28f Location /	Street an	d Number or Ri	ural Boute No	mher
or A after Direction by	Certification:	4 Homicide determined	build	ing, etc. (Specify)	eet, lactory	, onice		City or To			3/2/10000140	imbor,
spitel ours nerel filled			vsician: To the	best of my know	wledge, death	occurred a	at the time, dat	e and place	and due to the	cause(s)	and manner as	stated	
e Hos 24 h e Fur letely	edical	(Check only 2 Medical Examone)	niner: On the b	asis of examinat ner stated.	ion and/or in	vestigation,	in my opinion,	death occu	rred at the time,	date and	place, and due	to the cause	e(s)
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	N	29b. Signature and title of certifier		All.	din	£ 29c	License num	per		29d. Dat	e signed (Mont	h, Day, Year)	
	1	Marlan	Pri	77/00	NYD!		D369	142		Man	eh 8	200	5
1)		30. Name and address of part on who	completed caus	se of death (Item	23a) (Type,	Print)				71.0			
		15 TURAKHI	9 M	1009	Fre	linic	k Re	(A	FONSU	We,	NY	2122	-8
S Regis	tate	31. Date filed (Month, Day Year) 8	2005 32.F	istrar's Signat	ure	Jacobs.							

		Type or Print in B State of Maryland		lible Ink. Ensure a ment of Health and	_	_	ole.
	1 - For State Registrar			icate of Death		Reg. No.20	05 0770
Physician /Medical	Call	Junio		Statham City, Town, or Location of Dea	2. Date of De Month	Day .	Year 9:40 An
Examiner	Sinai Hosi	oital of Balti	more.	Baltimore (144		or Death
Funeral Director	5. Social Security Number 6. 219-44-8112 Usual Residence of Decedent	Sex 7. Age (In yrs. la 1 ☑ M 2 ☐ F 58		Under 1 Year If Under 24 Hr onths Days Hours Mir	. (Month, D	nth ay, Year) 08 46	Birthplace (State or Foreig Country) MD
Maryland Maryland -1 show	10a. State 10b. County		Town or Location			·	10d. Inside City Limits
with the Mar with the Mar the or 28e-1 el	MD NA 10e. Street and Number	Ba	ltimor	e Of. Zip Code		10g. Citizen of W	1 □XYes 2 □ No
atham redeath with the M redeath with the M sems 23e or 28e-1 armust be notified.	2837 Edgecomb			21215		U.S	. A .
1 . 9 = 5 l.	11. Marital Status 11. Marital Status 12 Married 2 Married 2 Married 3	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Pue Yes 2 ፟፟፟ No Specify:	Specify Yes or Note of Rican, etc.)	14. Race Blace Specify.	- American Indian, K, White, etc.
5-0036 72 hours at neturel, or alcal Exam	15. Decedent's	Education	16a. Decedent	s Usual Occupation	ndkina	16b. Kind of Bu	
21215-00 21215-00 ed within 72 hou yegiene neture ser then "neture t, the Medical E	Elementary/Secondary (0-12)	College (1-4or 5+)		of work done during most of wo NOT use retired) Glazer	n King	City	f Baltimore
ind 2					me (First, Middle	o, Maiden Sumam	
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other then sumetic event, the Mercompletic Percompletion and Percompletion and Percompletion Percomp		Time Drintl	10h Mailin A		Taylo		7.07
Baltimore, Maryland 21 Baltimore, Maryland 21 Bentier, Pages 1 and 2 should be filed w Department of Health and Mental Hygier Inportent: If them 27 is marked other th any injury or other treumetic event. In	Carrie Wortha		\$45 m - 13 m/s	idress (Street and Number or F Edgecomb_Cir		1000 0001	
Baltimore, Misperman Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other treesones	20a. Method of Disposition 1 🖫 Burial 2 🔲 Cremation 3	20b. Pla	ice of Dispositio metery, cremato	n (Name of ry or other place)	Date	20c. Location -	City or Town, State
Tim Tim Tim Tim Tim Tim Tim Tim Tim Tim	' 4 ☐ Donation 5 ☐ Other (Special Control of Special Control of Speci	ity) Kin	_	rial Park 3/	11/05	Randal	lstown, Md
Bal Bal Depa Impo	> Donald	C. Triums	Mar	ch F/H West O Wabash Ave	. Balt	imore.	Md 21215
	23a. Part1. Enter the disease, or co	mplications that caused the death. y one cause on each line.	Do not enter th	e mode of dying, such as cardia	c or respiratory a	ırrest,	Approximate Interval Between Onset and Death
Pnysician / /Medical	Impediate Cause (Final ease or condition resulting in death)	a. Pheumo Due to (or as a conseque					5 days
Examiner	Sequentially list conditions	b. Emph	15em	a			20 years
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a 🕏 nseque	o (ce of):				/
	resulting in death) Last	C. Due to (or as a conseque	ence of):				
6876 tificate be tig physici as the bu		d					
O. Box ne death cer the attendir hed for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ect	opic pregnancy er (specify)		23d. Date Mon	of delivery th Day Year
	Part II. Other significant conditions		-		23e. Did	tobacco use contri	bute to the cause of death?
cords w require been sig should b		cer, Diabet	rs M	ellitus	×	Yes 2□No	3 Probably 4 Unknown
The law requirate has been spage 2 should	Bipolar	Disorder			24a. Was auto perfo	psy pr	fere autopsy findings available for to completion of cause of eath?
Vital Recsicien: The law secutificate has be lirector, page 2 s	25. Was case refer en to medical	nsion		26. Place of De	1 ☐ Yes ath (Check only		☐ Yes 2 ☐ No
of V Physic this ce al direc	1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2 E		DOA Other: 4 Nursing			
Jing After fune	1 Natural 5 Pending 2 Accident investigati	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurre	a
Division of Vital Records, To the Hospitel or Attending Physicien: The law requires twithin 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street,	factory, office	28f. Location (City or To		r or Rural Route Number,
he Hospit in 24 hour he Funere pletely fille	29a. Certifier 1 Certifying F (Check only 2 Medical Execute)	Physician: To the best of my know miner: On the basis of examination and manner stated.	ledge, death occ on and/or investi	urred at the time, date and plac gation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
To troin within com	29b. Signature and title of certifier	NE		29c. License number RES - OC	0		(Month, Day, Year) +, 2005
2	30. Name and address of person who	completed cause of death (Item)	23a) (Type, Print HOSP)	tal of Bal	timor		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire er	1, 07	,, ,,,,		
Registrar	MAR 0 8 2005	la .					
S. 1881 17 FIGV 1/2001		Lean & A	MICHAL				

			1- State of Maryland / Department / Department / Dep			jiene	05	07704
	Physici		1. Decedent's Name (First, Middle, Last) KATHERINE CORINA SMITH	0/U/ JA	2. Date of Dea Month MARCH	th Day	Year 005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MARCII	4c. County		9:55A [™]
			1628 HOMESTEAD STREET	BALTIMORE		N/A	Ą	
	Funeral		5. Social Security Number 6. Sex 1 M 2 T	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	, Year)	Coun	
ш	Director		Usual Residence of Decedent		02/08/	1923	MAR	YLAND
	ryłanc how		10a. State 10b. County 10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Be-f s	Director	MD N/A BALT	IMORE				1X Yes 2 □ No
	ter death with the Marylan Items 23e or 28e-f show Items 1951 by realified at	Dire	10e. Street and Number 1628 HOMESTEAD STREET	10f. Zip Code	1	Og. Citizen of \	What Coun	try?
	ns 23	Funeral		21218 Was Decedent of Hispanic Origin? (Spe	acity Yes or No-	USA 14. Bac	e - Americ	an Indian
396	d within 72 hours after death with the Maryland piene. rr then "neturel", or Items 23e or 28e-f show the Medical Exammer out the modified at	by Fur	Y V Never Married 2 □ Married 1 □ Yes 257 No	Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes	Rican, etc.)	Blac	ck, White, μ_{c} $\mathrm{BL} A$	etc.
21215-0036	72 ho 'netur	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki	na	16b. Kind of Bu	usiness/Inc	lustry
21	within ene. then "	mpje	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	''y			
2	illed v I Hygie other t		8TH 17. Father's Name (First, Middle, Last)	DOMESTIC 18. Mother's Name	(First Middle I		ESTIC	
Maryland	b d d	To Be	SAMUEL SEWELL		ON MAS		10)	
ary	d 2 should be th and Mental t7 Is marked of treumetic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rura			State, Zip	Code)
	E # Z t		THOMAS SEWELL / SON 5211		LTIMOR	E, MD	2120	6
Baltimore,				natory or other place)		20c. Location -		
Iţim				200 march 4 4 4 4 4 700	5/05		LUAR	D, MD
Ba	permit. Departr Import eny inj		Wille Elfenil 1 4	600 LIBERTY HGH	TS. AV	E., BA	HOM LTTM	IE 21207 IORE, MD
,	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		r respiratory arro	est,		Approximate Interval Between Onset and Death
8760,	be executed ician and burial-transit	dicai Examiner	Sequentially list conditions, if any leading to thin additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):		L			
9	n certificate anding phys use as the	Φ.	IF FEMALE:	- 344				
.O. Box	death e atte	Physician/M	23b. Was decedent pregnant in the past 12 months 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Dat Moi	e of deliver	y Day Year
rds, P	sign sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tob			e cause of death?
I Records,	The law ate has b page 2 si	Completed	Demotia		24a. Was an autops perform	y p	Vere autoporior to com leath?	sy findings available pletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only on	9)		~
of	Phys this al dii	. To	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Mann of Death		ne 5 4Reside 28d. Describe ho		er (Specify)	
O	ding After fune	tion	27. Mann of Death 1 Autural 5 Pending (Month, Day Year) 2 Accident investigation	Work? M 1 □ Yes 2 □ No	d. Describe no	w injury occurr	90	
Division	To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		28f. Location (Sti City or Town	reet and Numbe , State)	ar or Rural	Route Number,
	To the Hospitel or within 24 hours after to the Funerel Director completely filled in I	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred	and due to the ca	tuse(s) and ma ate and place, a	nner as sta and due to	ted. the cause(s)
)	To the Youth it comp	Me	29b. Signature and title of certifier Annual M	29c License number		Date signed		
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, M. And A CVD East 33		Homer	Maryla	-1-	21218
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 0 8 2005	rs.				

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MILDRED Month Day Year SMETH 8:50 AM MARCH 4,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. UNIVERSITY OF MARYLAND MEDICAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🎖 F 72 216-24-3152 Director ΜĎ 05/13/1932 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 17 is marked other than "naturel", or liems 23a or 28a-f ehow traumatic event, the Madical Examinet must be nutified at MDN/A BALTIMORE ty Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA Completed by Funeral 1131 MCKEAN AVENUE filed within 72 hours after death .E. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ∑ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIETARY TECH STATE OF MD 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If tiem 27 le marked oth any injury or other traumatic event 2002. 18. Mother's Name (First, Middle, Maiden Sumame) HENRY CORNISH MAUDE HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORETTA LAWRENCE/DAUGHTER 2203 KOKO LANE, BALTO., MD 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS * 4 ☐Donation 5 ☐ Other (Specify) 3/11/05 BALTO., MD 21. Signatore of Euneral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 23a. Part Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pheumonia DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The faw requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 20 No 1XYes 2 🗆 No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Apatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2× No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 125Natural 5 Pending 1 TYes 2 No investigation 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number s of person who completed cause of death (Item 23a) (Type, Print) 9 22 S. GREENE 21201 Registrar's Manatures 31. Date filed (Month, Day, Year) Registrar

OLO	00		For State Registrar	State of M		artment of Hea		ental Hygie	2000	07706
	Physici	an	1. Decedent's Name (First, Middle,			12.4.).		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Darryl	L e e		Smith	15	March 2,	2005	08:08 P.™
	Examin	er	4a. Facility Name (If not institution, s Cedley Street ar			4b. City, Town, or Loc			4c. County of Deat	n
	Funeral			Sex 7. A	ge (In yrs. last birthday)			8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign
	Director		215-08-4908	1 M 2 □ F	19 Yrs.	Montalo Suyo III		6-16-8		Md.
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	e Man	ctor	Md. NA		Balti	lmore				12 Yes 2 □ No
	vith the	Director	10e, Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	ns 23e	Funeral	1002 E. Biddle	St.	Ever in U.S. 13.	21202 Was Decedent of Hispa	nic Origin? (Spe	cify Yes or No-	USA 14. Race - Ame	ncan Indian,
9	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show tra Madical Extralled and the mollified at	Fun	1 Never Married 2 Married	Armed Forces	? No	Was Decedent of Hispa If Yes, specify Cuban, M 1 ☐ Yes 2 No S	Mexican, Puerto F	Rican, etc.)	Black, White	
21215-0036	ureľ,	d by	3 Widowed 4 Divorced	Year or Dates:						Black
15-	in 72 t	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of workin	g 16	b. Kind of Business/	Industry
212	d with giene.) Juo	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	mer Jobs			Varies	
р	be filed within 72 hours after death with the Marylan hal Hygiene. Id other than "neturel", or litems 23a or 28a-1 show event, it is Marical Execution.	Be	17. Father's Name (First, Middle, La	st) Lee	Smith,		Mother's Name Ericka	(First, Middle, Ma.	iden Sumame) Ward	
Maryland	12 should be filed within and Mental Hygiene. Fis marked other than "reumatic event, If a Mar	유	Darryl 19a. Informant's Name/Relationship			ng Address (Street and				Zin Code)
Ma	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Ericka Ward	Mother		2 E. Biddle			*	21202
Jre,	as 1 au of Hea fitem rothe		20a. Method of Disposition	□ Dameual from State	20b. Place of Dispo	osition (Name of matory or other place)	D	ate 20	c. Location - City or	Town, State
Baltimore,	Pages Iment of I Iant: If Ito jury or of		1 Donation 5 Other (Spe	cify)	Mt. Carr	The second second	3-10-		Dundalk,	
Ball	permit. Pages 1 and 2 Department of Health ar Important: if Item 27 is eny injury or other treu once.		21. Signature of Funeral Service Li	p Wa		Name and Address of March F.H.			nore, Md. North Ave	21202
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause by one cause on each	d the death. Do not entline.	ter the mode of dying, su	uch as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Mulh		shot wa	unds			
	Examiner				a consequénce of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequence of).					
/	and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):					
8760,	be executed sician and burial-transit	al E		_ Due to (or as	s a consequence on.					
9	g physi as the	edical		0						
Box	death certifica attending pt d for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth		☐Ectopic pregnancy			23d. Date of del	ivery Day Year
.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	1 Yes 2 No 9 Unknown	4☐ Pregnant a 9☐ Unknown	at time of death 5	Other (specify)			World	ouy rou
Q.	res that the de igned by the be detached	by Ph	Part II. Other significant condition	s contributing to death	but not resulting in the u	inderlying cause given in	Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	w requires been sign should be	ed b						1 🗌 Yes	2 □ No 3 □ Pr	obably 4 Unknown
eco	ne law requ has been ge 2 should	Completed						24a. Was an autopsy	prior to a	itopsy findings available completion of cause of
E B		Con						1 Yes 2	d? death?	2 No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 XYes 2 No	Hospital:	ient 2 ER/Outpatie	Other		(Check only one) ne 5 ☐ Residence	on Afficiation (Con-	2,50
o	₽ ₽ ₽	n: To	27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Time o			8d. Describe how		At scene
sion	stendin death. ctor; Aft y the fun	atlo	1 Natural 5 Pending 2 Accident investiga	tion 3-3	- 05 20:0		2 X No	Subje	ct sh	ot
Division	el or Attending Ph s after death. N Director: After th of in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Place of it	njury - At home, farm, st htc. (Specify)	reet, factory, office	2	8f. Location (Street	et and Number or Ru tate)	ent 54
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (of examination and/or in	th occurred at the time, ovestigation, in my opinion				
	To th withir To th compl	Me	29b. Signature and title of certifier		200 4	29c. License nu	ımber		Date signed (Monti	
			Maturille	ini-t	Stell n	OCME		Ma	rch 3, 20	05
	2		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,	Print) 111 Penn	Street	Baltimo	re, Maryl	and 21201
	Sta	ite	31. Date filed (Month, Day, Year)	MONICA	trar's Signature	Con the				
	Registi		MA	K A O KMB	AMERICAN ST	1				

			For State Registrar	State of M		d / Depa		f Healt	h and M	lental Hyg	iene	005	0771	n 7
			Registrar 1. Decedent's Name (First, Middle, La	atl				n Dea	.,,	2. Date of Dea	eg. No.		3. Time of De	oth
	Physici	an		-						Month	Day	Year	5:00a	М
	/Medic	al	Jerome	Steffe			4b. City, Tow		ing of Dooth	March	1,	2005 ounty of Death		
	Examin	er	4a. Facility Name (If not institution, give		,							Montgo		
			Friends Nursing 5. Social Security Number 6.5		ao /la ure	ast birthday)		-	Spring		- L		place (State or Fo	oreign
	Funeral Director		114-01-3196	1 M 2 F 7. A	84	Yrs.	Months Da			8. Date of Birth (Month, Day April	12,19	20 Nev	V York	
Aaryland	edat	ō	Usual Residence of Decedent 10a. State 10b. County Manual and Montage		10c. City	, Town or Lo		. Cna	ina				10d. Inside City L	
with the !	a or 28a- be notif	Director	Maryland Montgo 10e. Street and Number 17340 Quaker Lai				10f. Zip Coo	y Spr 10 20860	1118	1	_	on of What Cou	-	
aath	18 23	era		12. Was Decedent	Ever in II	S 13			Origin? (Sp	acify Yes or No-		. Race - Ameri		
Q Z I Z I D-UU30 filed within 72 hours after death with the Maryland	ntal Hygiene. nd other than "natural", or Itams 23a or 28a-f ehow event, Its Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	? No	1	If Yes, specify 0			ecify Yes or No- Rican, etc.)		Black, White,		
IZIO-0030 within 72 hours af	"natural	Completed t	15. Decedent's E (Specify only highest gr	ducation		16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use re	cupation one during	most of work	ing	16b. Kind	of Business/Ir	ndustry	
<u> </u>	than	du	Elementary/Secondary (0-12)	College (1-4or	5+)		ofessor				IIni	vorcit	y Educat	ion
V pe	Hygie ther nt, II	ပိ	17. Father's Name (First, Middle, Las.			110	7162201			(First, Middle,			y Educat	1011
aryiand should be file	d d	To Be	Joseph L	. Spi	ege1				Elizab	eth		Katz		
2 2	モトコ		19a. Informant's Name/Relationship Heidi Steffens			9414	4 Thorn	n i 11 :		ilver Sj	-		20901	
nore,	Department of Heali Important: if Itam 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [14 ☐ Donation 5 ☐ Other (Speci	Removal from State	9		osition (Name or matory or other ke Crema		 			ation - City or T Beltsvil	own, State	
SAITIMOR Dermit. Pages	Departme nportan ny injur		21. Signature of Funeral Service Lice	nsee		2: - I	2. Name and Ad Rapp Fui	ddress of F	acility and C	remation	n Ser	vices		
L a			Hiple & Rohin	00000	10038.	- (933 Gisi	Ave	., S11	ver Spr	ıng,	MD 20	0910 Approximate	
	rysician Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	ıne. .a1 In	suffic				h gangre			Interval Betwee Onset and Dea 2 month	ath
	xaminer	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Obsease of Injury	b. Due to (or as										
(bo executed		Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	s a conseq	uence of):								
Hecords, P.O. Box 68 The law requires that the death certificat	e attending pt od for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	death 3	□Ectopic pregna				23	d. Date of deliv Month	ery Day Yea	ır
Tat The C	ad by the detached	Phys	9 ☐ Unknown Part II. Other significant conditions		but not res	ulting in the u	underlying cause	given in P	art I.	23e. Did to	bacco use	e contribute to t	the cause of deat	th?
Records, he law requires t	s been signed be should be det	ted by	Chronic Obstr	uctive Pul	monar	y Dise	ease			1 🗆 Y	es 2XXX	No 3□Pro	bably 4 🗆 Unk	.nown
Hecc be law r	this certificate has be ral director, page 2 sh	mple	Dementia					****		24a. Was a autops perfor	sy med?	prior to co death?	opsy findings ava empletion of caus	ilable se of
		e C	Parkinson's D	isease				26.0	lass of Doct	1 ☐ Yes		1 🗆 Yes	2 L No	
Scia <	certi	O B	examiner?	Hospital:	iont 2	EB/Outpetio	nt 3 DOA	0.1		me 5 Resid		Other (Special	441	
on of	After this funeral di	I	1 ☐ Yes 2 📉 No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	jury	28b. Time of Injury	of 28c.	injury at Work? 1 Yes		28d. Describe h			iy)	
DIVISION OF VITA To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Diractor; After th completely filled in by the funeral	Certification;	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	28e. Place of Ir	njury - At ho etc. (Specif	ome, farm, st				28f. Location (S City or Tow		Number or Rur	al Route Number	٠.
- Hospita	24 hours e Funeral etely filler	Medical C	29a. Certifier 1X Certifying F (Check only one) 2 Medicel Exe	hysicien: To the bes miner: On the basis and manner s	of examina	wledge, deat tion and/or in	th occurred at the	ne time, dat ny opinion,	e and place, death occur	and due to the cred at the time, d	ause(s) a late and p	nd manner as s lace, and due t	stated. to the cause(s)	
o the	o the	Me	29b. Signature and title of certifier				29c. Lic	ense num	ber	2	9d. Date	signed (Month,	Day, Year)	
,	s = 0		1 ANARA	\times				D00	35045		Mar	cch 4,	2005	
	10		30. Name and address of person who Philip G. Henju	o completed cause of	death (Iten	1 23a) (Type	Print)	t #20	4; Oln	ey, MD	2083	32		
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa		M a	0	,					
	Regist	rar	MAR 0 8 200	a diameter	· A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	For State Registrar		, (Certificate of	Death	F	Reg. No.	5 0/	108
, Physiciar		1. Decedent's Name (First, Middle, L	oseph Siek	Lioki			2. Date of Dea Month	ath Day	Year	of Death
/Medica	1			LICKI		1	MARCH	3, 200		10p M
Examine	r	4a. Facility Name (If not institution, g Gilchrist Hos			Tows	r Location of Death		4c. County o	ltimore	
Funeral				e (In yrs. last bin	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h	9. Birtholace (State	or Foreig
Director		179-16-5899	1 X M 2□F	84	Yrs. Months Days	Hours Min.	MAR 3,	1921 P	ennsylvar	nia
Now I I		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside	
72 hours after death with the Maryland natural, or items 23e or 28e-f show diesi Examiner must be notified at	פָׁ	Maryland Harfo	rd		Havre de	Grace			1 ☐ Ye	es 2 XNo
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?	
23a		1514 Superio	r Street			1078		US		
tems Tal	Funeral	11. Marital Status	12. Was Decedent Amed Forces?		13. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Race Black,	- American Indian, White, etc.	
Sf., or l	Dy	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ∑Yes 2 ☐ h If Yes, Give Year or Date <i>s</i> :	WWII	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White	
lene. This "natural", or items 23a or 28a-f show the Medical Examinet must be nuitible at	Completed	15. Decedent's (Specify only highest of	Education rade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of work	ring	16b. Kind of Bus	iness/Industry	
than than	dmo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Boilermaker	-		Const	ruction	
it the		17. Father's Name (First, Middle, La.	st)		DOLLCLIMATEL	·	e (First, Middle,	Maiden Sumame,		
9 6 6	10 Be	John Sieklicki				Alic	e Kibit	lewski		
S III		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Address (Street	and Number or Run	a <i>l Route Numb</i> e	er, City or Town, S	tate, Zip Code)	
Health tem 27 I		Carol S. Knight	/daughter	15	14 Superior	Street	Havre de	e Grace,	MD 21078	3
of it		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3	☐Removal from State		Disposition (Name of ry, crematory or other place		Date		ity or Town, State	
ant:		`4 ☐ Donation 5 ☐ Other (Spec	city)	Metro	Crematory,				ore, MD	
Department of Important: If it is any injury or conce.		21. Signature of Funeral Service Lic	AMCUMO	W.	Cremation	Society	of Mary	land, In	c.	
02.60	-	Dawn F	. McDonald	I the death. De	299 Frede					ato
-		23a. Part1. Enter the disease, or co shock, or heart failure. List on	y one cause on each li	16.	- 7		or respiratory an	rest,	Approxim Interval B Onset and	etween d Death
ysician Medical		Immediate Cause (Final disease or condition resulting in death)	W1	crite					wee	+S
aminer			Due to (or as	a consequence	of):					
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):					
ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury) that initiated events								
sicien and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence	of):					
physicies the bu	Medical		d							
ing pt	Med	IF FEMALE:								
for use	an	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		у		23d. Date Mont		Year
by the a	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)					
0 0		Part II. Other significant conditions	contributing to death b	ut not resulting in	n the underlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	oute to the cause of	f death?
. p g	d by						1 🗆 Y	res 2 No 3	B Probably 4]Unknowr
s been si should	Completed						24a. Was	an 24b. W	ere autopsy finding	s available
this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	E O							rmed? de	ere autopsy finding ior to completion of ath?] Yes 2 No	cause of
# 5 0	a a	25. Was case referred to medical				26. Place of Deat		/	1165 20140	
direc	10 8	examiner? 1□Yes 2⊠No	Hospital:	ent 2 ER/Ou	utpatient 3 DOA Oth	ner: 4 \(\tag{Nursing}\) Ho	ome 5 Resid	dence 6 Other	(Specify)	010
ter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. 1	Time of 28c. Injury	ry at rk?	28d. Describe h	now injury occurred	t	1
death. ctor: At y the fu	äti	2 Accident investigat	on		M 1	Yes 2 No				
Direct	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of Inj building, et	ury - At home, fa c. <i>(Specify)</i>	irm, street, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	r or Rural Route Nu	mber,
					e, death occurred at the ti					
in 24 the Ft pletel	edical	one)	aminer: On the basis o and manner st		id/or investigation, in my o	opinion, death occur				
within 2 To the	Σ	29b. Signature and title of certifier	1 1.	0	29c. Licens	se number		_	(Month, Day, Year)	
		(// Hos)	my Kr	Ky, L	~ y23	105		rngrch	3, 2000	>
1		30. Name and address of person wh	o completed cause of c	leath (Item 23a)	(Type, Print) N. Charle	St 2	elds in	nd 2 - 5	A 6	
1		111 H. C. (2)	0 ////	1000	14-			- (-	- /-	

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 8 2005

32 Registrar's Signature

		1	For State Registrar	State of Marylan			t of Hea e of De			ene 2005	07709
			Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death
	Physicia		Carolyn	A. Seibert					Month MARCH 4	4, 2005	4:35p M
ì	/Medic		4a. Facility Name (If not institution, give st			4b. City,	Town, or Lo	cation of Death		4c. County of Deatl	
Н	Examin	er	1208 Topaz Court				0den	ton		Anne A	rundel
	Euporal		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under		Under 24 Hrs.	8. Date of Birth	9. Birtl	nplece (State or Foreign
	Funeral Director			M 25 F 60	Yrs.	Months	Days	Hours Min.	SEPT 24	, 1944 Ma	ryland
			Usual Residence of Decedent								
	ylan		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Ma-f	to	Maryland Anne Aru	nde1	Od	lentor	1				1 ☐ Yes 2 ☐ No
	h the	Directo	10e. Street and Number			10f. Zip			10	g. Citizen of What Co	untry?
	within 72 hours after death with the Marylan tiene. Than "natural", or tems 23a or 28a-f show the Medical Examine must be notified at		1208 Topaz Cour	t			211			USA	
	dea dea	Funeral	11. Walital Status	 Was Decedent Ever in U Armed Forces? 	.S. 13. V	Was Deced	dent of Hispa orly Cuban, I	anic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
õ	or the		1 Never Married 2 Married	1 ☐ Yes 2 🔼 No If Yes, Give		1 🗆 Yes	2 X No 5	Specify:		Specify: W	hite
ğ	aral',	d by	3 Widowed 4 Divorced	Year or Dates:	1 12 2		10			Ch. Kind of Business	
٨	72 nat	ete	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	kind of wo	al Occupation In done during In retired	n ing most of worki	ng	6b. Kind of Business/	ridustry
2	within ane. than	Completed	Elementary/Secondary (0-12)	Coltege (1-4or 5+)			,	hnologi	st	Hospita	1
7	filed within 72 hours after death with the Maryland tygiene. other than "natural", or Items 23e or 28e-f show other than "natural", or Items 23e or 28e-f show ont, I'm Medical Examinat must be notified at		17. Father's Name (First, Middle, Last)		1100				(First, Middle, M		
ğ	b d la b	Be	Boyd Root						red Bach		
Maryland 21215-0036	should by nd Menta marked imatic e	2	19a. Informant's Name/Relationship (Typ	ne Print)	19h Mailin	ng Address	(Street and	Number or Rura	il Route Number.	City or Town, State, 2	(ip Code)
ā	2 c c c c c c c c c c c c c c c c c c c		Delbert S. Seiber				z Cour		ton, MD		
	of Health item 27		20a. Method of Disposition	20b. F	Place of Dispo	sition (Na	ne of			0c. Location - City or	Town, State
0	S to the		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		emetery, crer	natory or c	ther place)	10.13/5/0	05	Baltimor	e. MD
Baltimore,	permit. Page Department i Importent: If any Injury or once.		`4 □Donation 5 □ Other (Specify)						-		c, 1m
gai	ermil Separ mpor ny Ir		21. Signature of Funeral Service License	inala						and, Inc.	220
	GU 2 8 G		Dawn F. McDon. 23a. Part1. Enter the disease, or complice	ald	b Do not out	299 Fi	rederi	CK ROAG	Baltim	ore, MD 21	Approximate
7.8 3.5 8			shock, or heart failure. List only on	e cause on each line.	n. Do not ent	ei the mot	le or dying,		or respiratory arre	31,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cralafelt	Vac	elis	Cli	reose			
	/Medical Examiner		resulting in death)	Due to Grass a consec	(uence of):						
		<u>.</u>	Sequentially list conditions b	Due to (or as a consec	ulence of):						
Т	pe psit	-lue	f any, leading to immediate cause. Enter Undertying Cause (Disease or injury	200 (0 (5) 23 2 2011000	1401100 017.						
V	and and I-tran	Examiner	that initiated events cresulting in death) Last	Due to (or as a consec	uence of):						
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	a E									
	phys the	dical	0								
9 X	leath certific attending pl	/Me	IF FEMALE: 23	3c. If yes, outcome of pregn	ancy					23d. Date of del	ivery
Box	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		⊒Ectopic p ⊒ Other <i>(s</i> ;		_		Month	Day Year
	that the de ed by the detached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown			, , , , , , , , , , , , , , , , , , , ,				-
P.0	res that the signed by be detact	l P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying a	cause given	in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Records,	sign d be	d by							1 ☐ Ye	s 2.10%No 3.∏Pr	obably 4 Dunknown
Ö	w requir been si should	Completed							24a. Was ar	24b. Were as	atopsy findings available
3e	has has	m							autops) perform	prior to death?	completion of cause of
a	The icate har									No 1 ☐ Yes	2 No
Ž.	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	ospital:			Other		h (Check only one		
of	Physicien: this certific ral director,	2	1 Yes 2 No	1 Inpatient 2	28b. Time o		OA 28c. Injury a		28d. escribe ho	nce 6 Other (Spe winjury occurred	city)
Ľ.	ling After funer	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	м	Work?	s 2□No			
isic	Attending it death. ector: After by the fune	cat	3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, st				28f. Location (Str	reet and Number or Ri	ural Route Number,
Division	or A after Direct in by	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)		,,		City or Town	, State)	
_	Hospital 14 hours a Funerel i		29a. Certifier	sician: To the best of my kn	owledge, deat	th occurred	at the time.	date and place.	and due to the ca	use(s) and manner as	s stated.
	Hos 24 hc Fun Fun	edical	(Check only 2 Medical Examination)	ner: On the basis of examin and manner stated.	ation and/or in	rvestigatio	n, in my opir	ion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Mec	29b. Signature and title of contriber			29	c. License r	number	25	d. Date signed (Mont	h, Day, Year)
	F ≯ F 8			$\wedge n \wedge$		1.7	726	958		3/5/09	-
	/		30 Name and address of parson who as	ompleted causey of death (Ite	m 23a) (Tuna		00	1		10100	
	h		30. Name- and address of person who ac	Culhu 14	13 A	120 /	olis	Kund =	# 106 1	Ochen Ton	MD 21113
	() ()	ate	31. Date filed (Month Day Year	2. Registrar's Sign	ature	an Wall	V LAA	- way	1 100	- LUJU	.,,.
	Regist		MAK U 872005	diana A	A STATE OF THE PARTY OF THE PAR	100					

			For State of Maryla State of Maryla		artment of Heartificate of De		ntal Hygie	7009	07710
			Decedent's Name (First, Middle, Last)			2.	Date of Death		3. Time of Death
	Physicia		Lily . M. SchereR	2		n	Month	Day Year 2 <i>06</i> 9	5 11:26 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County of Deal	
	Examin	٠.	GOOD SAMARATAN HOSPITA	AL	BALT	TIMERE		NA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yr	rs. last birthday)		Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
	Director		219-18-2490 10M20F 75	Yrs.	Monard Bayo	r	1A4 14, 14	726	My.
	S DG		Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Lo	cation				10d. Inside City Limits
	sho	5	MD NA		BALTIMON	2			Yes 2 No
	the N	Director	10e. Street and Number		10f. Zip Code		100	Citizen of What Co	ountry?
	with e or		419 . N. GLOVER . ST.		212	24	1.53	U. 5.	
	eath	Funeral	11. Marital Status 12. Was Decedent Ever in	1 U.S. 13.1	Was Decedent of Hispa f Yes, specify Cuban, N		y Yes or No-	14. Race - Ame	
"	r Iten	μĒ	1 Never Married 2 Married 1 Yes 2 No				an, etc.)	Black, Whit	
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1□Yes 2☑No S	Specify:		Specify:	hite
21215-0036	filed within 72 hours after death with the Maryland Hygione. Ither than "naturel", or Items 23e or 28e-f show ent, the Medical Examirat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during	n na most of workina	166	. Kind of Business	Industry
21	thin e.	nple	Flementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)			Home.	
2	ygier ygier ner th	So	12th NIA		Housev		Timb Adjuddle Adei		
pu	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)		18	. Mother's Name (F	4.1 1.0	аөп зитате)	
3	2 should be filed within and Mental Hygiene. Is markad other than eumatic event, the Me	2	John P. WillHeim 19a. Informant's Name/Relationship (Type, Print)	10b Maili	ng Address (Street and	Mumber of Pum I S	HACK Pours Sumber S	ity or Town State	Zin Code)
Maryland	d 2 sl th and 7 Is r treur	1	Philip Scheter		n. GLOUE			No 212	4
	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. It of Health and Mental Hygiene. If item 27 is marked other than "naturel; or thems 23e or 28e-f show to ther than" and the houst termatic event. The Medical Examinating must be notified at			p. Place of Dispo	sition (Name of	Dat	9 200	. Location - City or	
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or otha once.		Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crer	natory or other place) Ribse Cel	2/8/	5 7	Po ito. Nu	
Ħ	permit. Pag Department Importent: I any injury o		21. Signature of Juneral Service Licensee	22	2. Name and Address of	of Facility	((= ==================================	eral Hor	ne CHTD.
Ba	permit. Departr Importe any inju		Vaul M. Stella	t	2. Name and Address of HARTIEM MIL 5 27 ha (En	1ex - 012	Balto No	21234	
			23a. Part. Enter the disease, or complications that caused the de						Approximate Interval Between
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Uncher	INC FO	FACOTA	1		Onset and Death
	/Medical		resulting in death) Due to (or as a cons	sequence of):					MINITES
81	Examiner		Go	rtic 1	ROOT DIS	Sutur			princia
,=	2	ner	if any, leading to immediate Due to (or as a cons	sequence of):					
	and errans	Examiner	o,		Vasuin	~ DigeA	٠		40005
90,	law requires that the death certificate be executed as been signed by the attending physician and should be detached for use as the burial-transit	ă	resulting in death) Last Due to (or as a cons	sequence of):					
8760,	icate be ex physician s the buria	dical	d					·	
9	ding page as	/Me	IF FEMALE: 23c. If yes, outcome of preg	gnancy				23d. Date of de	livery
Вох	that the death certific ed by the attending p detached for use as	Physiclan/Me	23b. Was decedent pregnant 1 Live birth 2 F	etal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	the de	ysic	in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown 4 □ Pregnant at time of 9 □ Unknown	71 40411	2 04101 (0000%)/				
<u>α</u>	res that I	y Ph	Part II. Other significant conditions contributing to death but not i	resulting in the u	nderlying cause given i	in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	uires n sigr	d by					1 🗆 Yes	2 No 3 ₽	robably 4 Unknown
00	w require been signal	Completed					24a. Was an	24b. Were a	utopsy findings available completion of cause of
Re	9 7 9	шо					autopsy performed 1 Yes 2	death?	
ta	icien: Th certificate rector, pag	Be C	25. Was case referred to medical		26	6. Place of Death (710	22110
of Vital	ysici is cer direct	0	examiner? 1 Yes 2 No Hospital: 1 patient 2	2 ER/Outpatier	nt 3 DOA Other:	4 Nursing Home	5 Residenc	e 6 ∏Other (Spe	city)
0	g Ph ter th neral	n; T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Injury at Work?	28	d. Describe how	injury occurred	
0	Attending r death. ector: After by the fune	atlc	2 Accident investigation			s 2 No			
Division	r Atter de irecte	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	urs af					<u> </u>			
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Check only (Check only one) and manner stated.	knowledge, deat nination and/or in	h occurred at the time, vestigation, in my opini	date and place, and ion, death occurred	at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	thin 2 the othe	Med	29b. Signature and title of certifier		29c. License n	umber	29d.	Date signed (Moni	th, Day, Year)
	E 3 E 8		& Colom A	~	000	255	17	3/2/.	
	ch		30. Name and address of person who completed cause of death (I	Item 23a) (Type	Print)	3 3 3	1 . 1	to No 3	1120
	X		Kenreth Silver Ms.	5601	Print) Coch Rp	von BLUD	100	ל פטן י ידין	1751
	Str	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signary	ignature	hasti 5				
	Regist		MAR 0 8 2005	, D. P.					

		-	For State	State of M	narylano		artmen rtificate			and Me	•		200	5 07711
			Registrar 1. Decedent's Name (First, Middle, La	act)			incur	0 01 2	Jean		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	n	1. Decedent's Name (First, Middle, La								Month	Day	Yea	r
	/Medic	al	John Howard	Smith							Februar			
	Examin	er	4a. Facility Name (If not institution, given	ve street and number	r)		4b. City,		Location o			4C. (County of De	aan
			Sinai Hospital						timor				n/a	
	Funeral			Sex 7. A 1 X M 2 ☐ F	Age (In yrs. la:		If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day April 2	h v, Ye <i>ar</i>)	9. B	Sirthplace (State or Foreign Country)
	Director		213-46-3280	TAIN ZUI	_ 57	Yrs.					April 2	5, 1	94/ N	Maryland
	p ,	-	Usual Residence of Decedent		10c City	Town or Lo	oation							10d. Inside City Limits
	sryla shov	_	10a. State 10b. County											1X Yes 2 □ No
	Pa-f	cto	Maryland n/a		В	Baltim	ore							
	th th	Funeral Director	10e. Street and Number				10f, Zip	Code				10g. Citiz	en of What	Country?
	th wi	<u>a</u>	4800 Seton Drive	2				2121	15				USA	
	dea Fin	ner	11. Marital Status	12. Was Deceden Armed Forces	nt Ever in U.S	13.	Was Deced	dent of Hi	ispanic Orig	gin? (Spec	cify Yes or No- Ricen, etc.)	- 1	4. Race - An Black, Wi	merican Indian,
9	after or Ite	교	1 ☐ Never Married 2 ☐ Married	1 Tes 2 1			1 ☐ Yes :			.,			Specify: _	1110, 010.
8	rel',	5	3 XWidowed 4 ☐ Divorced	Year or Dates):		10 163 7	294110	ороспу.				V	Mhite
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-f show than "meturel", or Items the Medical Extentinet must be rediffied at	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	dent's Usua kind of wo			t of workin	10	16b. Kir	d of Busines	ss/Industry
7	hin .	P P	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	DO NOT us	se retired)					
21	d wit	PO.	08	n/a		Ca	ıb Dri	iver				T	ranspo	rtation
	othe vent,	Be	17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle,	Maiden .	Sumame)	
<u>a</u>	ld be lenta ked ic e	To E	Samuel J.	Smi	th				1	Blanc	he		Abre	sch
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinating Providing of once.		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Numbe	er, City or	Town, State	a, Zip Code)
≥	od 2 Ith a 27 Is		Wanda L. Smith-Ge	erher/Daug	hter	35 P	ickbu	ırn (Court	. Coc	keysvi	11e,	Mary1	and 21030
တ်	1 ar Hea Herri	1	20a. Method of Disposition	erber, baag	20b, Pla	ace of Dispo	sition (Nan	me of		3/7/				or Town, State
و	ages of of		1 ☐ Burial 2 X Cremation 3 [(0	metery, crer	-					T	1 1	f 1
Baltimore,	tmer tent tent		'4 □Donation 5 □ Other (Spec		Balt	timore								Maryland
39	ermil epal npol ny ir nce.		21 Signature of Funeral Service Lice	CUUX9										ey Inc.
	20 5 g d		Bryan W. Clary			1	0 W.	Pado	onia l	Road,	Timon	ium,	Maryl	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caus ly one cause on each	ed the death. line.	. Do not ent	ler the mod	de of dyin	g, such as	cardiac or	r respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition										11	Onset and Death
	/Medical		resulting in death)	_ a	1 7 31		1. 5	1001	-11 C43	CCC	(Y) la 1-		1160 101 (1)	(
	/iticaloa.			Due to (or a	as a conseque	ence of):	K ES	nal	4126	426	en he	- muc	1421	
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		er	Sequentially list conditions, if any, leading to immediate		as a conseque	ence of):						enve	1420	2
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State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MARCH **Physician** 03, 2005 6:10 Charles Jerome Smith, Sr. /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore If Under 1 Year tf Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) 6. Sex **Funeral** Months Days 1₩ 2□ F Hours Director Nov. 14 1921 MD 215-16-1404 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 45 Belfast Rd. 21093 USA death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ Not 42-144 If Yes, Give 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: If Yes, Give Year or Dates: white 3 Nidowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Sanitation Engineer n/a Sanitation Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fand Mental P and Menta John Smith Esther M. Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 ls 45 Belfast Rd., Charles J. Smith, Jr./Son Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 3/7/05 permit. Pages Department of Important: If it any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Funeral Service Scenses 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Rd., Timonium, MD 21093 Michael S Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEHYDRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): attending physicien Physician/Medical as the tF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DEMENTIA certificate has page 2 autopsy performe 2 No 2 X No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After i or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Tella Mo 03 D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 M. D 7601 **JOGINDER** MEHTA. 31. Date filed (Month, Pay Year) 32. Restrar's Signature State 8 2005 Registrar

				State of Maryland / Department of Health and N	-	_	07713
				Registrar Certificate of Death		g. No.	01110
	Р	nysicia	ın	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
		Medic		EDNA AGNES SCHOOLS SUMMERS	March	3, 2005	11:20 P.™
	Е	xamin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
				Gilchrist Center Towson		<u>Baltimor</u>	e
		neral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 M 2 F 95 Yrs. 1 Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign intry) cyland
	Dir	ector		218-03-3064 1 M 2 N F 85 Yrs. Solution 1 S S S S S S S S S S S S S S S S S S	June 25	, 1919 Mai	- yrand
	and			10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	the	i ii	ect	Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code	11	Og. Citizen of What Co	intry?
	with	3 4	ā	400 Georgia Ct. 21204		U.S.A.	,
	eath		Funeral Director		ecify Yes or No-	14. Race - Amer	ican Indian,
	fter d		ᇤ	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
	036 Lrs a	D TEN	by	If Yes, Give 1 ☐ Yes 2 1 No Specify: 3 1 Wildowed 4 ☐ Divorced Year or Dates:		Specify: Wh	ite
	2 Po	cal	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/l	ndustry
6	21. Fig. 1	Med	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	ing		
000	gien gien	4	No.	7 years Homemaker		Own Home	
ğ .	Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene.	Vent	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N	Maiden Sumame)	
	aryland 2121 2 should be filed within and Mentat Hygiene.	item z'i is markad olina tran matura, o'r teins zoa o'r zeer snow other traumatic avent, the Medical Examinar must be notified at	10	Edward Lee Schools Lonie	Ţ	homas	
S	2 sho	E PUR		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number,	City or Town, State, Z.	ip Code)
5	and Salth	er tra		Barbara A. Pecoraro (daughter) 614 Debaugh Ave. Tows			
J	es 1.	r oth			Date 2	20c. Location - City or 1	own, State
A	Pag nent	o Arr		1♥Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Moreland Memorial Park 3-	-7- 05]	Baltimore,	Maryland
MARCH	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene.	any njury or other trai		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell - Windorfold	Euroro1	Uomo Tno	
\subseteq	മ ഉപ്	E & 8		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld 6500 York Road Ba	ltimore	Maryland	21212
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between
	Pnys	ician					Onset and Death
		dical		Immediate Cause (Final disease or condition resulting in death) a			8
	Exan	miner		covery artery dese	ASE		yen
B			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.			0
Pry,	cute	ransi	Examiner	Cause (Disease or injury that initiated events c.			
0	760, te be executed	burial-transit		resulting in death) Last Due to (or as a consequence of):			
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no	D d gu	Arter this tuneral di	on:	1 XNatural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe ho	w injury occurred	,
2	/ision Attending r death.	or: A	cati	2/ Accident investigation M 1 Yes 2 No			
7	V Att	in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Ru: n, State)	ral Route Number,
5	Ditai ours a	led					
,	DIV	lo the Funeral Director: After this certificate no completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)			
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		X		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
		11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. R. (e., C.B.M. 670) N. Charle	20 St. 1.	Salto. M	19 5179x
		Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature		-	
	F	Registr		MAR 0 8 2005			

MARCH 3, 2005

1130 Pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005

	-	Registrar										Reg. No.			
Physician	n	Decedent's Name (First									Date of De Month	Day	1	/ear_	3. Time of De
/Medica	al .	Elizabeth									ARCI		QU		10:54
Examine	er	4a. Facility Name (If not in		- 1	umber)	-0	4	b. City, Town, o	-		-		County of		174
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DHMH 17 Rev 1/2001

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/Medic	al .	4a. Facility Name (If not institution, give	ta mer			4h City T	Town or I	Location o	4 Dooth	MA		200 County of De		254/
Examine	er	Howard County	Luch	465/	14/41		~_ /	nb 1 4			1	Lora Ja		
Funeral		5. Social Security Number 6. Se		e (In yrs. la	st birthday)	If Under	-	If Under 2	·	3. Date of Birt	h V Yearl	9. B	irthplace (Sta	ate or Foreign
Director		213-70-3607	□M 2 X 1F	49	Yrs.	MOHUIS	Days	Hours	1	3. Date of Birt (Month, Da 0-5-19	55		Journay)	MD
land	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation							10d. Insic	de City Limits
Mary a-f sh	tor	MD Howard			Co1umb	oia							10	Yes 2X No
ith the	Olrec	10e. Street and Number				10f. Zip					10g. Citiz	zen of What (Country?	
He High within 72 hours after death with the Maryland tal Hygiene. The Waryland of other than "natural", or tems 23s or 28s-f show event, I'm Madical Examitment at the modified at	Funeral Director	6065 Majors Lane					210					US		
ter de Items	nue	11. Marital Status 1X Never Married 2 Married	12. Was Decedent 8 Armed Forces? 1 Yes 2 1		ef			panic Orig , Mexican	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)	- 1	4. Race - An Black, Wh		ın,
urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	••	1	☐ Yes 2	X No	Specify:				Specify: W	hite	
72 hours natural',	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	ent's Usual kind of worl OO NOT use	Occupat	tion urina most	of working	7 1	16b. Kir	nd of Busines	s/Industry	
within ane. than	Idm	Elementary/Secondary (0-12)	College (1-4or 5	+)		okkeep okkeep		3	•		Coca	-Cola	Bott1	ing Co.
filled Hygid		17. Father's Name (First, Middle, Last)					-	18. Mothe	r's Name (First, Middle,	Maiden :	Sumame)		
uld be Aental rked c	To Be	William	Ward	Sr.				Cath	erine	e Elear	nor I	Citus		
2 shot and N Is ma		19a. Informant's Name/Relationship (7								Route Numbe				
and and the salth		Mr. Jerry Stamer/k	rother	OOL BI						en Bur				
ages 1 nt of H or or ot		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐			ace of Dispos metery, crem sapeak				Da 3/5/2			cation - City o vensvi		
permit. Pages 1 and 2 should be filed within 72 ho permit. Pages 1 and 2 should be filed within 72 ho limportani: If item 27 is marked other than "natur any Injury or other traumatic event, If a Mudical once."	1	*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		One		. Name and				-				
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5.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death.									Approx	I Between
Physician		Immediate Cause (Final disease or condition	a Polmo	on Ar	4	Em	ايطا	usm					Onset a	and Death
/Medicat Examiner		resulting in death) a ue to (or as a consequent of):												
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									-			
cuted	Examiner													
		resulting in death) Last Due to (or as a consequence of):												
cate b	dlcal		d	·										
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of d	elivery	
death e atte	Iclar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			□Ectopic pregnancy □ Other (specify)					100	Month Day Year		
that the de led by the a	hys	9 Unknown	9□ Unknown											
gne d	by	Part II. Other significant conditions contributing to death but not resulting in the underlyin					use giver	n in Part I.				se contribute		
w require been si should b	eted	preumaso 10	- 7N Y	1/6	[W				_	1 🗆 Y				Unknown
The law cate has b	Completed									24a. Was autop perfor	sy	24b. Were a prior to death?	completion	ngs available of cause of
	°C	25. Was case referred to medical						26 Place	of Doath /	1 Yes	21 X No	1 □ Ye	s 2 No	
ysician: is certific director.	To B	examiner? 1 Yes Sal No							□Other (Sp	Other (Specify)				
ding Ph After th funeral								28c. Injury at Work? 28d. Describe how injury occurred Work?						
tendi Jeath. Tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be		415		М		es 2 🗆 N	-					
l or Al after of Direc	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	ury - At non c. (Specify)	ne, tarm, stre	et, factory,	office		28	f. Location (S City or Tow		Number or I	₹ural Route I	Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) (Check only one) (Check only one)	ysician: To the best of	examination	rledge, death on and/or inv	occurred a	t the time	, date and nion, deat	d place, an	d due to the o	cause(s) a	and manner a place, and du	as stated. Le to the cau	ısə(s)
ro the vithin;	Mec	29b. Signature and title of certifier	and manner sta			29c.	License	number			29d. Date	signed (Mor	nth, Day, Ye:	ar)
		Howall	m EV	LAL	tul.	2	04	13 Z	-0		MA	-/3	20	05
17)			completed cause of d	eath (Item :	23a) (Туре, 1	exit)			<i>~ 1</i>	bia,	7. (1.	,	и.	
		Howard J- Mo 31. Date filed (Month, Day, Year)	///S Magistra	ar's Signati	75J	Ced	Ar C	4 (0/1	vb19,	Md	- 210	74	
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		1 - For State Registrar	State of Maryla		artment of rtificate of			giene 005	07716		
Physi		1. Decedent's Name (First, Middle, Las	STIZAW				2. Date of Dea Month	Day Year	3. Time of Death		
/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D		4c. County of Dea			
Exam	illiei •	HOWARD COUNT	Y GENERAL H	OSPITAL	1	IMBIA		HowAl			
Funera	al	5. Social Security Number 6. Se	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	r If Under 24	Hrs. 8. Date of Birti	h 9. Bir	thplace (State or Foreign		
Directo		056.30.5700	M 2□F	66 Yrs.	Months Days	Hours	November		- Vermont		
pu »		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	nation		November	7, 1000			
anyla shov	ក			only, TOWN OF LE					10d. Inside City Limits 1 ☐ Yes 2 No		
he M	Director	Maryland Ho	ward			Columbia		10g. Citizen of What C	/\		
be filed within 72 hours after death with the Maryland half Hygiene. He Hygiene has consequently or Items 23a or 28e-1 show event, the Medical Exercites must be notified at								U.S.A.			
eath	Funerai	5475 Columbia Road; A	12 Was Dagadant Eyes in	U.S. 13.	Was Decedent of						
fter d	뜶	1 Never Married 2 Married	Armed Forces!		-/		? (Specify Yes or No- uerto Rican, etc.)	Black, Whi			
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1□ Yes 2No	Specify:		Specify:	White			
3-UU30 72 hours af netural', or	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	dent's Usual Occu	ipation	working	16b. Kind of Business	/Industry			
within ene.	ap du	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retir	ed)		Bridge C	ge Construction			
MA Z I Z e filed within il Hygiene. other than	ું		2+		Proje	ect Manage					
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	-			
Tarylar Tarylar 2 should be and Mental is marked eumatic ev	ပို		I. Straw	401 14 11				abel C. Bennett			
IOre, Maryle ges 1 and 2 should it of Health and Mer if item 27 is marke or other treumatic		19a. Informant's Name/Relationship (7	,, . ,					r, City or Town, State,			
C, R 1 and Health m 27 ther tr		Ms. Eileen B. Straw 20a. Method of Disposition	Spouse 20b.	_	osition (Name of	na Road; A	pt. 628 Columb	bia, Maryland 21			
Pages nent of lint: If its		1 Burial 2 Cremation 3	Removal from State	cemetery, crei	matory or other pl						
Darrit. Pages Department of I		'4 Donation 5 Other (Specify 21. Signature of Furieral Sewice)			Chapel Cem 2. Name and Addr	erery 1	03/12/2005	Butta	alo, NY		
Dantimore, in permit. Pages 1 and Department of Heal importent: if item 2 any injury or other	alla	- Wollow of Land	Aid I May	292	Slack	Funeral Ho	me, P.A.				
EYR-A'L	7	23a. Part1. Siler the disease, or composhock, or heart faill the List only of	dications that caused the de	ath. Do not ent	3971	Old Calumb	nia Pika Filicott	City, MD 21043	Approximate		
Dharaisia		shock, or heart failure. List only of	0						Interval Between Onset and Death		
Physiciar /Medica		disease or condition resulting in death)	a. Due to (or as a conse						HT40MJ		
Examine	r		IMMUNOS		SION				ZIASK		
	e e	Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a const	r(to connaupe							
cuted	Examiner	Cause (Disease or injury that initiated events	· BRONCHIO	LITIS C	BLITERA	INS OR	JUISINAD.	PHEMONITIS	5 YEARS		
O, exect an ar rial-tu		resulting in death) Last									
cate be executed physician and the burial-transit	dicai		d								
rdiffica ng ph		IF FEMALE:							* 1		
death certific	ician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnant	су		23d. Date of de Month	livery Day Year		
the described for	Sici	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5	Other (specify)			WORTH	Day rear		
· - 6 d	Physi	Part II. Other significant conditions of	entributing to death but not re	eulting in the u	andorhina course -	woo in Bad I	23e Did to	bacco use contribute to	the rause of death?		
COTOS, P w requires that s been signed b should be deti	by	CRYPTOCOCCAL	-	-	, ,		1 □ Y		robably 4 Unknown		
ecords, law requires t as been signe	Completed										
ער ייי אויי	ш	BICUSPID AORTICI					24a. Was a autop perfor	an 24b. Were at sy prior to the death?	utopsy findings available completion of cause of		
Page 1		HYPOTHY ROIDISM	CHOLELITHIA	515,05	TEPPOSC	515	1 ☐ Yes	2∡No 1□Yes	2 🗆 No		
OT VICAL Physicien: 1 this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:				Death (Check only or		•		
Phys r this	1	1 Yes 2 No 27. Manner of Death	i Minpatient 21		nt 3∐ DOA f 28c. Inju	4 ∐ Nursir		lence 6 Other (Spe	city)		
on ding I th. After funer	ţ	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 8b. Time of Injury Work? 1 Yes 2 No						,,			
DIVISION I or Attending after death. Director: After	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number,				
affer affer d in the	erti	4 Homicide	building, etc. (Spec	cify)			City or Tow	m, State)			
DIVISION OF VICE To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy	vsician: To the best of my ki	nowledge, deat	h occurred at the t	ime, date and p	lace, and due to the o	cause(s) and manner as	stated.		
he Hu in 24 he Fu pletel	edical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	nation and/or in	vestigation, in my	opinion, death o	occurred at the time, o	date and place, and due	o to the cause(s)		
To the transfer of the transfe	Z	29b. Signature and title of Certifier				SZ96	2	29d. Date signed (Mont			
		Affilian h	B		DS	5 4 16		MARCH 3, 2005			
1,0		30. Name and dess of person who de	completed cause of death (Ite	ет 23а) (Туре,	Print)						
1		JOSEPH F. GIBBOR	1020 dW/	OFDAN	NAPOLIS	RD, Sui	JE 505	SLLIGHT (Tr, MD 21042		
Renis	tate	31. Date filed (Month, Day, Year) MAR 0.8.2005	. 2. Registrar's Sig	nature	<i>M</i> .	-			;		

		For State Registrer	State of Marylar	-		of Health and of Death		Reg. No.	UUJ	07717
Physicia /Medica Examine	al .	1. Decedent's Name (First, Middle, Las Eugle 4a. Facility Name (If not institution, give	Scott		4b. City, T	own, or Location of De	2. Date of D Month O2	2812		3. Time of Death
Funeral Director		Howard Coun 5. Social Security Number 6. Se	ty benera 7. Age (In yrs.		If Under 1	Columb .	irs. 8. Date of B (Month, D	ay, Year)		plece (State or Foreign ntry)
Maryland	tor	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo	ocation	Ellicott City	March (30, 192		Montana 10d. Inside City Limits 1 □ Yes 2 No
th with the 23s or 28sust be not	Funeral Director	10e. Street and Number 3000 North Ridge Rd.			10f. Zip (10g. Citi	izen of What Cou	•
Jrs 8	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			Was Decede If Yes, speci 1 Yes 2	ent of Hispanic Origin? fy Cuban, Mexican, Pu No Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ameri Black, White Specify:	
d within 72 he giene. or then "netu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupation k done during most of the e retired) unknown	working	16b. Ki	ind of Business/Ir unki	ndustry NOWN
2 should be filed wilt and Mental Hygiene Is marked other tha aumatic evant, Ire.	To Be C	17. Father's Name (First, Middle, Last)	ne Scott	19b. Maili	na Address	18. Mother's N		ylvia u	nknown	p Code)
2 6 2 8		Ms. Ophelia Ross 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Legal Guardian		751 Col	umbia Gateway		or Colu		and 21046
permit. Pages 1 and Department of Health Important: If item 27 any injury or other fr		4 □ Donation 5 □ Other (Specify 21. Signature of Fundral Service Licen Neumlelle	lel min 3	5	SI	Services, Inc. Address of Facility ack Funeral Ho	me, P.A.		Sykesville	Maryla nd
Physician /Medical Examiner		23a. Part1. Enter the disease or compands, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the deal one cause on each line. a	erial	Λ	71 Old Columb of dying, such as card		att City,	, MD 21043	Approximate Interval Between Onset and Death
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse							
tificate be ng physicia as the bur	Physician/Medical E	IF FEMALE:	d	ancy					23d Date of deli	
that the death cer ed by the attendir detached for use	hysician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3[death 5[□Ectopic pre □ Other (spe	ocify)			23d. Date of deliv Month	Day Year
w requires that s been signed E should be deta	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	ınderlying ca	tuse given in Part I.	_ 1 _	Yes 2	□No 3□Pro	the cause of death? bably 4 Striknown
siclan: The law certificate has rector, page 2 t	e Completed	25. Was case referred to medical				26. Place of I		opsy formed? 2-2 No	prior to co	opsy findings available ompletion of cause of
ng Phys	ation: To B	examiner? 1 Yes 25No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of fnjury		A Other: 4 Nursin Bc. Injury at Work? 1 Yes 2 No	g Home 5 Res 28d. Describe			(fy)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Il Certification:	3 Suicide 6 Could not be determined		ify)			City or T	own, State	•)	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medicel Exercises 29b. Signature and title of certifier	niner: On the basis of examin and manner stated.	ation and/or in	vestigation,	in my opinion, death o	ccurred at the time	, date and	d place, and due to	to the cause(s)
\		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,		043725		3	11/05	21221
Stat Registra		TARZ (Q MAL) 31. Date liled (Month, Day, Year) MAR U 8 200	2. Registrar's Sign		13ack	River	Vecle	nd	15alt	rmore

DHMH 17 Rev 1/2001

			1 - State Registrar	State of Marylan		artment tificate			and M		iene ()	05	07719
	Physici	an	1. Decedent's Name (First, Middle, Last)	C : 4 h						2. Date of Deat Month March	h O4	2005	3. Time of Death
	/Medic	al	Dorothy R. 4a. Facility Name (If not institution, give s.	Smith		4h City T	Four or	Location of	of Dooth	March	_	ZUU5	18:43 ^M
	Examin	er	1496 Heron Road	ireet and number;			asad		or Death			e Arur	ndel
	Funeral		5. Social Security Number 6. Sex	3.17	last birthday)	If Under 1		If Under		8. Date of Birth	1		lace (State or Foreign
	Director		212-40-4233	M 250F 62	Yrs.	MOTITIS	Days	Hours	Min.	NOV 1	1942	Court	MD MD
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Mary F-f sh	to	Maryland Anne Ar	rundel		F	Pasa	dena					1 ☐ Yes 2 ☑ No
	or 288	lirec	10e. Street and Number			10f. Zip (10	0g. Citizen o	f What Coun	itry?
	23a cast	raiC	1496 Hernon Road					211	22			USA	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show says injury or other traumatic evant, I'm Madical Exertif actional be notified at ance.	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Was Decede fYes, speci 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Wh	
ည်	72 ho	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	ient's Usual kind of work	l Occupa	tion	t of worki	na	16b. Kind of	Business/Inc	dustry
2	within ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use	e retired)				115 G	overni	ont.
2	filed v Hygie other 1	ပိ	12 17. Father's Name (First, Middle, Last)			IV		18. Mothe	r's Name	(First, Middle, M			lent
a	lid be lental ked c	To Be	Joseph Roho	ol					othy		llis		
Maryland 2121	and Management		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Number,	City or Tow	n, State, Zip	Code)
Σ,	and 2 ealth m 27 I	1	Leo B. Smith (spou					oad,		dena, Mi			
altimore,	iges 1 it of H if ite or ot		20a. Method of Disposition 1	emoval from State	face of Dispo	natory or ott	her place		larch	ı 07 I.	20c. Location		
<u>=</u>	artmer artmer ortant injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		en Hav	en cer		1	200	-			Maryland
Ba	Depa Impo any ir once			1				escope.		italling: d. Pasad			ome, P.A.
	5 7		23a. Part1. Inter the disea of complication of complications of the complete shock, or heart failure. The complete shock is the complete shock of the comp	cations that a used the death	n. Do not ent							ויוט בוו	Approximate Interval Between
17	Physician		Immediate Cause (Final disease or condition	OVA	CIA,) (_		And		2	Onset and Death
И	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):								y Swiess
		er	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):								
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):								
8760,	icate be ex physician s the buria	dicai	d.										
O. Box 6	ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pre Other (spe						ate of delive	ry Day Year
۳.	res that the de signed by the a be detached f		Part II. Other significant conditions confi	tributing to death but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use co	ntribute to th	e cause of death?
Records,	w requires been sign should be	ed by								1 ☐ Ye	s 2/10No	3 🔲 Proba	abiy 4 DUnknown
000	ie law requ has been je 2 shouli	Completed								24a. Was ar		. Were autor	osy findings available
<u> </u>		Com								perform		death?	npletion of cause of
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe			(Check only one			
Division of	After After	tion; To	1 Yes 20 No 1 1 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4 □ Nui at ? 'es 2 □ h	2	ne 5 N Peside 28d. Describe ho)
Divis	tal or Attendests after desti	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory,	office		2	28f. Location (Str City or Town		ber or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	d place, a	and due to the ca ed at the time, da	use(s) and nate and place	nanner as sta , and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of centier	/	1	29c.	License	number	, ,		d. Date sign		
1	5		*//fm	all	7	1	9	15	5)	/	MARC	H 7	2005
	6)		30 Name and address of person who cor	ecaro. 30	75	Print) Ho	500	tul	Dr	ie, O.A.	Burn	p ne	1.21061
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 8 2005	38 Registrar's Signa	ture	139	V					<i>J</i>	

			1 - For State Registrar	State of Maryla		artment of			giene 005	07720
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Harry M. Tuck	er				2. Date of Deal	Day 2005	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s	are Hosp	ital	Ros	or Location of Death)	Ba If	imol e
	Funeral Director		5. Social Security Number 6. Sex 219-22-1780	7. Age (In yrs	Yrs.	If Under 1 Yea Months Day		(Month, Day,	2,1930 Mar	thplace (State or Foreign ountry) YLand
	death with the Maryland ms 23s or 28s-f show r must be collined at	ctor	10a. State 10b. County Maryland Baltimor		ity, Town or Lo		imore			10d. Inside City Limits
	th with the 23a or 28	Funeral Director	10e. Street and Number 39 Willow Creek	Court		10f. Zip Code	21234	1	Og. Citizen of What Co	•
5-0036	ours after el', or Ite	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in the Armed Forces? 1 X Yes 2 No. 195 If Yes, Give Year or Dates: 195	1- 1	Vas Decedent of Yes, specify Cu ☐ Yes 2X N	Hispanic Origin? (Suban, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Whit	e, etc.
21215-0	perm t. Pages 1 and 2 should be filed within 72 hours Depariment of Health and Mental Hygiene. Importent: If item 27 le marked other than "naturel" any i⊣ury or other traumatic event, I' a Meulcal Exi once	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th Grade	ation completed) College (1-4or 5+)	(Give i	lent's Usual Occ kind of work don DO NOT use reti	e during most of wor red)	king	16b. Kind of Business, Baltimore Electric	
Raryland 2121	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Havry M. Tuck	er		0	18. Mother's Nar	ne (First, Middle, 1 herine)
	and 2 sho ealth and 1 m 27 le ma		19a. Informant's Name/Relationship (Typ. Mrs. Barbara Tucke	r (wife)	39 Wi	llow Cr	eek Court	, Baltimo		234
$\int \bigcup_{\mathcal{L}} \mathcal{L}_{\mathcal{L}} \mathcal{K}$ Baltimore,	t. Pages 1 tment of H rent: If ite		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Re 1 ★ ☐ Donation 5 ★ Other (Specify)	Ba	lt. Nat		tery 3/7	/05 E	20c. Location. City or Baltimore,	Maryland
Bal —	perm t. Departr Importr any in	F - 1	21. Signature of Funeral Source Doense 23a. http://does.com/licenses/source/sou	lla	9	705 Bel	air Rd., 1	Butimore	ineral Home 2, MD 21236	
8760,	Physician /Medical Examiner	dicai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Du to (or as a conse	quence of):		e Citis			Interval Between Onset and Death
P.O. Box 68	ath certifi attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnan Other (specify)	су		23d. Date of deli Month	ivery Day Year
rds, P.	w requires that the deben signed by the should be detached		Part II. Dther significant conditions cond		sulting in the un	derlying cause (given in Part I.	1	pacco use contribute to	
Division of Vital Records,		Completed by	arterio nephrosch					24a. Was al autops perform 1 🗆 res 2	n 24b. Were au prior to death?	atopsy findings available completion of cause of 2□ No
of Vit	dii d	To Be	T Tes 2 PNO		∃ER/Outpatient	JU DON	ther: 4 🗆 Nursing H		ence 6 Other (Spec	cify)
sion (ending F eath. or: After he funera	ation	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W	ury at ork? □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
Divis	To the Hospitel or Attending Pr within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral	Certification; To	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ify) 			City or Town		
	he Hosp in 24 hou he Fune pletely fil	Medical	29a. Certifier (Check only one) Certifying Physical Exemination Certi	icien: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, a <i>n</i> d due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MO			4 0 8 5 0		9d. Date signed (Month	
	10+1		30. Name/and address of person who cor	npleted cause of death (ite	m 23a) (Type, F	Print)	Squeen idr		CRMD 2123	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 8 2005	Registrar's Sign	ature	les .	*			

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DHMH 17 Rev 1/2001

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	Physici /Medic		1. Decedent's Name (First, Middle, Last) JUGNITA Thompson		-		2. Date of Death Month Mark		
	Examin		4a. Facility Name (If not institution, give street and number) Mevicy Medical Catter 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Balti	If Under 24 Hrs	h	4c. County of D Baltiw Year) 9.	,
	Director		219-26-9714	10c. City, Town or L		Tiours Will.	08 12	39	MD 10d. Inside City Limits
	e Maryla 3a-1 shov	ctor	MD NA	Baltimo	re		···		1 X Yes 2 □ No
	h with th	ai Dire	10e. Street and Number 123 North Luzerne Ave		10f. Zip Code	1224	10	$U \cdot S \cdot U$	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel', or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinational Legical and Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	No	Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes XXNo	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		Merican Indian, White, etc. Black
Maryland 21215-0036	nin 72 ho in "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	edent's Usual Occup a kind ol work done DO NOT use retired	ation during most of wo d)	rking 1	6b. Kind of Busine	ess/industry
d 21	filed with Hyglene othar the ent, the		10th grade na 17. Father's Name (First, Middle, Last)		Laundry	18. Mother's Nar	me (First, Middle, M		lto. Hotel
ylan	should be and Mental marked c	To Be	Cleve Harvey	405 14-18	Add (044	Eva Mi		City of Town Office	To Oada
	1 and 2 sho Health and tem 27 is mu		19a. Informant's Name/Relationship (Type, Print) Kim Thompson-Daughter	434	North		aral Route Number,	alto, M	d 21224
nore	ages 1 ant of He it: If iten y or oth		20a. Method of Disposition ★□Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		matory or other plac			Oc. Location - City	
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any Injury or other <u>90ce</u> .		21. Signature of Funeral Service Licensee	nes M	2. Name and Address arch F/ .300 Wab	ss of Facility H West ash Ave	, Baltin	more, M	Mills,Md d 21215
Į	Pnysician /Medical	G.		1	ater the mode of dyir	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner	ler		a consequence of):					
,092	icate be exacuted physician and s the burial-transit	cai Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as Due to (or	a consequence of):				_	
.O. Box 68	that the death certifical led by the attending phy detachad for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	/		23d. Date of Month	delivery Day Year
Δ.	uires that signed by	by	Part II. Other significant conditions contributing to death b	ut not resulting in the o	underlying cause giv	en in Part I.			e to the cause of death? Probably 4 □Unknown
Il Records,	The law requires cate has been sign page 2 should be	Completed					24a. Was an autopsy perform	prior	
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatie	ent 2□ER/Outpatie	ent 3 DOA Oth	Ar.	ath <i>(Check only one</i> dome 5 ☐ Resider		Specify)
ion of	To the Hospitel or Attending Phy. within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident 28a. Date of Inju	y Year) 28b. Time of Injury	Wo		28d. Describe hor		
Division	el or Atte s after des l Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	treet, factory, office		28f. Location (Str. City or Town,		r Rural Route Number,
	e Hospite 24 hours e Funera letely fille	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or in	th occurred at the time timestigation, in my o	me, date and place pinion, death occu	a, and due to the ca urred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
	within To th compl	Me	29b. Signature and little of certifier A INULE MO)	29c. Licens			d. Date signed (M	
	1		30. Name and address of person who completed cause of d		, Print)	1:160 1	11(1.	1 2:0	4,205
\	Sta			St. Gul F ar's Signature	kce, ix	HIMOVE,	Mary 12.	no 2/20)2.
	Regist	rar	MAR 0 8 2005	w A A	code				

DHMH 17 Rev 1/2001

Allen Thorn 05-1636 AKG

5			1 - State Registrer		of Maryl		artment of F			Reg. No.	005	0//22
	Physici /Medio		Decedent's Name (First, Mid	121	llen Le	ee Thorn	1		2. Date of De Month March	Day	005 Year	3. Time of Death 5:10 P M
	Examir	er	4a. Facility Name (If not institut 2852 Mayfield		mber)		4b. City, Town, or Baltimor		ath	4c. (County of Death	
I	Funeral Director		5. Social Security Number 219-25-2511 Usual Residence of Decedent	6. Sex 1 1		yrs. last birthday) 19 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th y, Year) , 1985	9. Birthp Coun Ma	ace (State or Foreign try) aryland
	Maryland a-f show	tor	10a. State 10b. Coun Maryland	ty N/A	10c.	. City, Town or Lo		ltimore			10	Od. Inside City Limits
	ath with the 23a or 28	rai Director	10e. Street and Number 2852 Mayfield Aven	ue			10f. Zip Code	21213		10g. Citiz	en of What Coun U.S.A.	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itams 23e or 28e-1 show any fourty or other traumatic event, I're Medical Exercifier must be notified at ODGE.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Maried 3 □ Widowed 4 □ Divorce	If Yes G	orces? 2 No ve	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🖾 No		(Specify Yes or No erto Rican, etc.)	}	4. Race - America Black, White, 6 Specify: Bl	
Maryland 21215-0036	within 72 hc ene. than "natur re Medical	ompleted	(Specify only high Elementary/Secondary (0-12	ent's Education nest grade completed) College (16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired Mail	ation during most of w d) Carrier	vorking	16b. Kin	d of Business/Ind	•
land 2	ould be filed Mental Hygi arked other latic event, I	To Be Co	12. 17. Father's Name (First, Middle	e, Last) rnest Thorn				18. Mother's N	ame (First, Middle,	Maiden S orgia T		
	nd 2 sho eith and f 27 is ma or trauma		19a. Informant's Name/Relation Georgia Thorn Mot						Rural Route Numberimore, Maryla			Code)
Baltimore,	Pages 1 a ment of He ant: If Item lury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other				sition (Name of natory or other place oudon Park	ce)	Date 03/10/05	20c. Loc	ation - City or To	
Bail	permit Depart Import any Inj		21. Signature of Funeral Service	M. Ede	$\overline{\mathcal{L}}$		Name and Addre Estep B 1300 Eu	rothers Fun Itaw Place	ieral Service Baltimore, Ma	aryland	21217	
68760,	Physician // Medical pasecuted is by physician and as the purial-transit	sal Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Hang (or as a con		er the mode of dyin	g, such as card	ac or respiratory ai	rrest,		Approximate Interval Between Onset and Death
Вох	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 ☐ F nant at time i	etal death 3	Ectopic pregnancy			23	d. Date of deliver	y Day Year
ords, P	equires that en signed t buld be det	by	Part II. Other significant condi	tions contributing to d	eath but not	resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	. 1	e contribute to the	e cause of death?
Division of Vital Records, P.O.	The lay	e Completed	25 Was seen referred to made						1 Yes	rmed? 2 \Begin{array}{c} No	24b. Were autop prior to com death? 1 X Yes 2	sy findings available pletion of cause of
ž Ž	Physicia this certi	ToB	25. Was case referred to medic examiner? 1 XYes 2 No	Hospital: 1 🗆		2 ☐ ER/Outpatien	t 3 DOA Oth		eath (Check only on Home 5 Resident		Other (Specify)	at scene
/ision	tending leath. tor: After the funer	Certification:	3 Suicide 6 ☐ Coul	tigation and description descr	th, Day Year 3 -4 -05 of Injury - A	Found 50		y at k? Yes 2 X No	28d. Describe h	treet and	occurred Number or Rural	Route Number
ă	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		* _ Nomicide	build	ing, etc. (Sp	ecity) At -la	ome	ne date and pla	Baltim	m, State)	2852 ma	yticid Ave
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only one) 2 X Medical (Check only one)	and man	asis of exam ner stated.	nination and/or inv	restigation, in my of	pinion, death oc	curred at the time,	date and p	lace, and due to	the cause(s)
	h			n uho completed cou	on of death "	ltom 02-1 CT		CME			ch 5, 20	* '
	Ŋ		30. Name and address of person LiNG L3 31. Date filed (Month, Day, Yea	, m.D	se of death (enn Stre	et Balt	imore	, Maryla	and 21201
	Sta Registr		MAD A	6	g	L 1						

			1 - For State Registrer		arylan		artment of F			Reg. No.	5	07723
	Physici /Medic		1. Decedent's Name (First, Middle, Hazel Franc		•				2. Date of De Month		rear	3. Time of Death
	Examir		4a. Facility Name (If not institution, University Spec	nive street and number) ialty Hospi	tal		4b. City, Town, o Baltimor			4c. County o	Death	
	Funeral Director		213-20-4983	A COLUMN TOWN	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da Oct. 30			lace (State or Foreign try)
	show	J.	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	rundel	10c. City	. Town or Lo	cation rna Park				10	0d. Inside City Limits 1 ☐ Yes 2₹☐XNo
	with the N a or 28e-f be notifi	Director	10e. Street and Number 309 Crandell Roa	ad			10f. Zip Code 2114	.6		10g. Citizen of Wh	nat Coun	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Mudical Enarth arrunal be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrier ★★Widowed 4 □ Divorced	12. Was Decedent Armed Forces?	?	1			? (Specify Yes or No uerto Rican, etc.)		White, 6	etc.
Maryland 21215-0036	within 72 ho ene. then "netur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed) College (1-4or	5+)	16a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retired	during most of d)	working	16b. Kind of Bus		lustry
land 2	uld be filed Jental Hygirked other tic event, t	To Be Co	17. Father's Name (First, Middle, La John Spitze	Ť	1		Homem		Name (First, Middle			own
, Mary	and 2 sho ealth and N n 27 is ma		19a. Informant's Name/Relationship Deborah Fisher	(Type, Print)		309	Crandel					code) and 21146
Baltimore,	. Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe	city)	Mar Mar	yland	sition (Name of natory or other place Veterns		^{Date} /7/2005	Garrison	For	est, MD
Bal	Departiment Important Impo		21. Signature of Funeral Service Lie	Hens	1/	136	OJI Palls	Koad.	z Funeral Baltimore	Marvla	nc.	21211
	Physician	100	23a. art1. F ter the disease, or conshock, in heart failure. List or Immediate Cause (Final disease or condition resulting in death)			n. Do not ent		ley	diac or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
	/Medical Examiner	Jé.	Sequentially list conditions	Due to (or as			0	<u> </u>				
8760,	certificate be executed rding physician and use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as				- ASICAL	THE PROVED BY M	MD		
.O. Box 68	death certifi e attending p id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date Monti		ry Day Year
s, P	sign sign d be		Part II. Other significant condition	s contributing to death b	out not resu	ulting in the u	nderlying cause giv	en in Part I.		obacco use contrib Yes 2 Y No 3		e cause of death?
of Vital Record	The law ate has b page 2 sl	Completed							24a. Was auto perfo 1 \(\text{Yes}	osy pri ormed2 de	or to com	esy findings available apletion of cause of
of Vita	Physician: The this certificate ral director, page	To Be	25. Was case referred to medical examiner? 1 ▼ Yes 2 □ No	Hospital: 1 Inpatie		ER/Outpatien		er: 4 Nursin	Death (Check only only only only only only only only	dence 6 Other)
Division	ding h. After fune	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Naccident investiga 3 Suicide 6 Could no	be ass Block of In	04	28b. Time of Injury	Wor M 1□	yat k? Yes 2. V No	Fe II	while ge	ttin <u>-</u>	Cav
Div	Hospitel or Attenc 24 hours after death Funerel Director: stely filled in by the	O	4 Homicide determin	Home	tc. (Specify	')	eet, factory, office	- data and al	3 501	keswick	Rd	Baltimore MO 4/4/1
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medical	(Check only one) 29b. Signature and title of certifier	Physician: To the best aminer: On the basis of and manner st	of examinat	ion and/or in	vestigation, in my o	pinion, death o	ace, and due to the occurred at the time,	cause(s) and mann date and place, an 29d. Date signed (d due to	the cause(s)
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	10		30. Name and address of person with the Control of	ensity spec		Huspit		cuth cha	irles st.	Baltimore	m0	21230
• •	Sta Regist		MAR 0		rars Signat		(1) (I)					

HAZEL TRACEY

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year **Physician** MARCH 6, 2005 6:30 A **TENBERG** DAVID /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE LUTHERVILLE COLLEGE MANOR NURSING HOME H Under 24 Hrs. 8. Date of Birth (Month Cay, Year) SEP . 23, 1914 If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ₩ M 2 □ F 90 Yrs. MD 216-07-6341 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No COCKEYSVILLE Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ŏ 21030 USA 12206 BOXER HILL ROAD or items 23a by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Pages 1 and 2 should be tited within 72 hours after nent of Heatth and Mental Hyglene.
ant: If Item 27 is marked other then "naturel", or itee ury or other traumatic event, the Medical Execution 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUDOW **TENBERG** GERTRUDE **JACOB** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12206 BOXER HILL ROAD - COCKEYSVILLE, MD 21030 MARVIN TENBERG / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) SEDEK 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State SHOMREI HADATH VE TZEMECH 3/7/05 ROSEDALE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208) occ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician DEMENTIA ADVANCED /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and -transit death certificate be executed Due to (or as a consequence of): physicien ar Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown COPD Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas rmed? 2 ☑ No page 1 ☐ Yes certificate Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 V Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: To the Hospitel or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier March 6, 2005 D16619 Eunjandoney mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 N. SEMINARY AVE LUTHERVILLE, M.D. 21093 C. VERGARA SOARES 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 08 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year MINTA TRIEBULL FEB 26 2005 11:30A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 Ct 21, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F 81 New York 063-18-9182 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene.
Is marked other than "natural", or Items 23a or 28a-4 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-1 show the Medical Examinations the notified at MDMontgomery Directo Rockville 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Calvin Lane 20851 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No white Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert LaRock Zana Isobel Corrigan ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Itam 27 i Ronnie J. Ferguson/son 404 Calvin Lane Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permif. Pages 1 Department of H Importent: if Its any injury or ot once. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wades Director State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street enous enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON SMALL CELL LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the ydd gulbr IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate 2X No 1 Yes 2 🗆 No 1 Yes or Attanding Physician: : After this certification of the things of Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ X o 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deal To the Funerel Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 28, 2005 VA 0101236796 reb Nace 1 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER FRANZOS LCDR MC USN 8901 WISCONSIN AVE BETHESDA MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registra MAR 0 8 2005

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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			State Registrar		Cei	rtificat	e of Death	1 -		. No.	0 / / 20
	Physicia		1. Decedent's Name (First, Middle, Last)					-	Date of Death Month	Day Year	3. Time of Death
	/Medic	al .	Charles Jerome Uttenr						ebruary	28, 2005 4c. County of Deet	
	Examin	er	4a. Facility Name (If not institution, give street and	(number)			Town, or Location of	t Death		Harford	
27	\$1	*	2012 Cypress Drive 5. Social Security Number 6. Sex	7. Age (In yrs. Ia	aet hirthday)		el Air	24 Hrs. 8.	Date of Birth		
	Funeral Director		1 DM 2 D		Yrs.	Months		Min.	Date of Birth (Month, Day, Y	(ear) Co	hplace (Stete or Foreign untry) Vland
16.5	^	1	218-36-4297 x Usual Residence of Decedent	1 04							
	yland		10a. State 10b. County	10c. City	, Town or Lo						10d. Inside City Limits
:	a-fal	to	Md. Harford			Bel.	Aır				1 Yes 2 No
	or 28	Jre.	10e. Street and Number			10f. Zi	Code			Citizen of What Co	untry?
	23a	Funeral Director	2012 Cypress Drive				21015			J.S.A.	
	r dea	nue	Arme	Decedent Ever in U.S d Forces?	5. 13.	Was Dece If Yes, spe	dent of Hispanic Orig cify Cuban, Mexican,	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
3	or I	by Fi	_ If Yes	es 2 ⊡ No s, Give or Dates:		1 🗆 Yes	2 No Specify:			Specify: Wh	ite
3	hour tural	ed b	15. Decedent's Education	or Dates.	16a. Dece	dent's Usu	al Occupation		16	bb. Kind of Business/	Industry
2	in 72	piet	(Specify only highest grade comple		(Give	kind of we	ork done during most ise retired)	of working			
-	r tha	Completed	Elementary/Secondary (0-12) Colle 12 years	ge (1-4or 5+)	Plar	nt ma	nager			candy ma	king
3	Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (F	irst, Middle, Ma	uiden Surname)	
<u> </u>	Alenta Alenta riked fic e	ToE	Charles Uttenreither						Simpson		<u></u>
<u></u>	and and is ma	•	19a. Informant's Name/Relationship (Type, Print)				S (Street and Number				
>	コミトラ		Edna A. Uttenreither/		J		press Driv	ve, be		Oc. Location - City or	
5	permit. Pages 1 and Department of Heatl Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f	rom State	lace of Dispo emetery, crea	matory or	other place)				
altillo altillo	Pa tmen tant:		'4 □Donation 5 □ Other (Specify) maus	soleum Pa	rkwood			/5/200		altimore,	
8	permit Depar Impor any in		21. Signature of Funeral Service Licensee	Rine			nd Address of Facility unek Fune 1				
	dor e a		22a Part I Enter the disease or complications t	hat caused the death	Do not en	510 W	MacPhail	1 Road	Bel A	Air, Md. 2	Approximate
			23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final	on each line.		<i>i</i> .			,		Interval Between Onset and Death
	Physician /Medical		disease or condition a.	e to /or as a consequ	uence of):	Car	ur				
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		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequ	uence of):						
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oo,	e be executed /sician and e burial-transit			e to (or as a consequ	uence of):	A	2	, C.			
-	ate be nysici he bu	icai	d	Caron	y "	AU	my 10	HIJON	75		
00	death certificate e attending phys id for use as the	Med	IF FEMALE:		/		1				
X O D	ath co	lan/	23b. Was decedent pregnant	s, outcome of pregna ive birth 2 ☐ Fetal Pregnant at time of de	death 3	⊒Ectopic p ⊒ Other (s				23d. Date of de Month	Day Year
5		Physician/Medio		Jnknown	eatii 5	_ Other (s	pocity/				
7.	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the		Part II Other significant conditions contributing	to death but not resi	ulting in the u	underlying	cause given in Part I.		23e. Did toba	cco use contribute to	the cause of death?
cords,	luires n sign ild be	d by	Distite W	estifuy					1 ☐ Yes	2 □ No 3 P	robably 4 Unknown
င္ပ	w req	lete	Frankl V	Arubu "	うい	700			24a. Was an	24b. Were a	utopsy findings available
Ē	sician: The law certificate has b irector, page 2 s	Completed	. 1						autopsy perform 1 ☐ Yes 2	ed? death?	completion of cause of
VII	an: T	0	25. Was case referred to medical				26. Place	of Death (C	Check only one	7	
	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 Hospital:	1 Inpatient 2	ER/Outpatie	nt 3 🗆 D	OA Other: 4 Nu	rsing Home	5 Residen	ce 6 □Other (Spe	cify)
0	ng PP fter th neral		27. Manner of Death 28a. I	Date of Injury (Month, Day Year)	28b. Time of Injury	of	28c. Injury at Work?		d. Describe how	injury occurred	
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DIVISION	of or Attendir after death. Director: Af d in by the fu	Certification:	determined 200.	Place of Injury - At he building, etc. <i>(Specif</i>		reet, facto	ry, office	281	City or Town,	et and Number or R State)	urai Houte Number,
	pitel ours a erel [29a. Certifier 1 ☐ Certifying Physician: 1	o the hest of my kno	wledge deal	th occurre	t at the time, date and	d place, and	due to the car	ise(s) and manner a	stated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Exeminer: On	the basis of examina manner stated.	tion and/or ir	nvestigatio	n, in my opinion, deat	th occurred	at the time, dat	e and place, and due	to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			25	c. License number		29	d. Date signed (Moni	th, Dey, Year)
)	. , - 0		1				B 242	76		3.3.01	
	$ \mathcal{T}_{i} $		30. Name and address of person who completed								
_	10		Simon Scalia, M.D.			treet	, Suite A	, Bal	timore,	Md.	
	Sta Regist	ate	31. Date filed (Month, Day, Year) MAR 0 8 2005	32. Registrar's Signa		ation of					
	11-1-11-1	12.1	MAR GO / HIEL W	Charles to D. H. B. C.	Action	The same					

DHMH 17 Rev 1/2001

			State of Maryland	d / Department of Certificate of			ene() ()	5 07	727
		1. Decedent's Name (First, Middle, Las	t)			2. Date of Deeth Month	Day		ime of Death
н	Physician	ROSE	WALSH			March 7		2005 6:	30 AM
	/Medical Examiner	4a Fecility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Deeth	4c. County	of Deeth	
Н		St. Joseph Nursin	g Home		Catonsvi	11e	Ва	altimore	
	Funeral	Social Security Number 6. Security Number	M 2187 F	Months Davs		(Month, Day,	Yeer)	Birthplace (S Country)	
	Director	202-56-1418	93	Yrs.		Dec. 31,	, 1911	Maryla	nd
	pu *	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City	, Town or Location				10d. Ins	ide City Limits
	Mary Feb or	Maryland Baltimo	ore (Catonsville				1 🗆]Yes 2√2 No
	1 the	10e. Street end Number		10f. Zip Code		10	g. Citizen of V	Whet Country?	
	ould be filed within 72 hours after deeth with the Maryland Mental Hygiene. Mental Hygiene. Arised other than "natural", or items 23a or 28a-f show after event, the Medical Examinar must be notified at To Be Completed by Funeral Director.	1222 Tugwell Aver	ue	2122	28		USA		
	deet deet	11. Marital Status	12. Was Decedent Ever in U,S Armed Forces?	S. 13. Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto	cify Yes or No-	14. Rac	e - American Indi	an,
9	or he or Fu		1 ☐ Yes 2 🛣 No	1 ☐ Yes 2 ☒ No		110411, 010.7		.White	
<u> </u>	rei. o	3 XWidowed 4 ☐ Divorced	Year or Detes:						
,	72 h	15. Decedent's Ed (Specify only highest gran		16e. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of worki	ng 1	6b. Kind of Bu	usiness/Industry	
2	led within 72 hor lygiene. her than "nature nt, the Medical I	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	80)		Own H	Iome	
N D	Hygie of the control	17. Fether's Neme (First, Middle, Last)		Homemaker	18. Mother's Name	(First, Middle, M			
aŭ	d be fill and the control of the con		nd		Rose An	n Fahey			
Maryland 21215-0036	should I of Meni marke imatic	19a. Informant's Name/Reletionship (7		19b. Mailing Address (Street	et and Number or Rura	l Route Number,	City or Town,	State, Zip Code)	
<u>∞</u>	trau	Dolores Costello	Daughter	5304 Brabant					
<u>6</u>	f Hea	20a. Method of Disposition		lace of Disposition (Name of emetery, crematory or other pl		Date 2	0c. Location -	City or Town, Sta	ate
Ë	Pege ento at: If	1 DaBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	w Cathedral Co		/10/05 B	altimo	re, Mary	1and
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar mast be notified at pince. To Be Completed by Funeral Director	21. Signature of Funeral Service Licen		22. Name and Add	ress of Fecility	land I. Don	1 T	T T	_
m	De F E	Melle	M01290	-	S Ashton Scondson Aver				
		23a. Part1. Epter the diseese, or comp shock, of heert failure. List only	dications that caused the deeth	n. Do not enter the mode of dy	ring, such as cardiac o	r respiratory arre	st,		oximate al Between
	Physician	shock, of heert failure. List only	one cause on each line.					On set	and Death
	/Medical	Immediate Cause (Final disease or condition	anteriore	Constitution coron	ary arte	ry des	rase	4	ears
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<u>о</u> .	tha d y the schec	Part II. Other eignificant conditions of			given in Fatt I.		s 212 No	3 ☐ Probably	
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Records,	v requires that the death certificate be executed been signed by the ettending physician end should be datached for use es the burial-trensit letted by Physician/Medical Examil					24a. Was an	autopsy	24b. Were aut	opsy findings prior to
ပ္သ	s bee					, ,		completion of death?	on of cause
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ta	certificata ractor, per				26. Place of Death	(Check only one)		
>	Physician: this certific ral diractor,	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3□ DOA C	other: 4 12 Nursing Ho	me 5 🗆 Resider	nce 6 🗆 Oth	er (Specity)	
0	g Ph ter th neral		28e. Date of Injury (Month, Dey Year)	28b. Time of 28c. Inj Injury W	ury at ork?	28d. Describe ho			
<u>ত</u>	Attending or death. Sctor: After by the fune fill cation	2 Accident investigation		M 1[Yes 2 No				
Division of Vital	tal or Attending P rs efter death. al Director: After t ad in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify	ome, farm, street, factory, offici ()	е	28f. Location (Str. City or Town,	eet and Numb State)	er or Rurel Route	∍ Number,
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	n 24 hour n 24 hour ne Funer plataly fil edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	/sician: To the best of my know liner: On the basis of examinat and manner stated.	wieuge, death occurred at the tion end/or investigation, in my	urrie, date end piece, a opinion, death occurr	and due to the ca ed at the time, da	use(s) and ma te and place,	and due to the ca	ause(s)
	ithin 2 or the o	001 001 1 1111 1 110		29c. Licer	nse number	29	d. Date signe	d (Month, Day, Y	'ear)
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1	9					4 -		2 -	
1) ,	30. Neme end address of person who can be a careful of the careful	LLAGER, MD	716 MAIDEN C	HUICE LANG	E, BAL	TOIM	0, 212	.23

State Registrar

31. Dete filed (Month, Day, Year)

MAR 0 8 2005



				State of Maryl	and / Depa		Health and	Mental Hygi	9	07728
Ī	Physici		1. Decedent's Name (First, Middle, Last) ELLA J'.	WOOD				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give si	•	L		or Location of Deat	h	4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday)	-	If Under 24 Hrs	8. Date of Birth		hplace (State or Foreign untry) MD
	aryland show	7.	Usual Residence of Decedent 10a. State 10b. County		. City, Town or Lo		•			10d. Inside City Limits 1 X Yes 2 ☐ No
;	or 28a-f	Director	MD NA 10e. Street and Number		Baltimo	10f. Zip Code		10	g. Citizen of What Co	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. After 18 marked other than "natural", or Items 23a or 28a-1 show other traumatic event, it is Modical Exactions?	by Funeral D	3401 Courtleigh 11. Marital Status 1	Drive 2. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates:			L 244 Hispanic Origin? (Sean, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	U S A 14. Race · Ame Black, White Specify: B	ncan Indian.
7-617	be filed within 72 hours after dial Hygiene. It hygiene. It other then "natural", or Item event, Ine Madical Exacultar.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	6b. Kind of Business/	Industry
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yıa	2 should be f and Mental P Is marked of raumatic eve	Tof	Aaron Lee 19a. Informant's Name/Relationship (Typ	a Printl	105 14-11	na Addresa /Ctrans		Goode	City or Town, State, 2	
Mar	alth an 27 is r		Maurice Wood Jr				eigh Dr		lto, Md	21244
ore,	iges 1 and 2 it of Health it If Item 27 is or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	b. Place of Dispo cemetery, crea	osition (Name of matory or other pla	ice)	Date 2	0c. Location - City or	Town, State
Baltimor	t. Partmer		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		2:	2. Name and Addre	ess of Facility	7/05 R	andallst	own, Md
ă	Depa Impo	L	Myrette	K. Jones	4	larch F/	bash Ave	, Balti	more, Md	21215
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	cause on each line. Co Ro NA Due to (or as a cor	RY I		_	c or respiratory arres	51,	Approximate Interval Between Onset and Death
		i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	isequetice of).					
08/	certificate to ding physicals as the b	edicai	d.							
n i	death e atter id for u	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pri 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y	·	23d. Date of deli Month	very Day Year
ŗ.	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions conf	ributing to death but not	t resulting in the u	inderlying cause gr	ven in Part I.		acco use contribute to	the cause of death?
Hec	The law ate has b page 2 st	Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
VItal	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	2050/2			ath (Check only one		
	p je l	I	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpaties 28b. Time of Injury	f 28c. Inju Wo	4 □ Nursing F ry at rk?] Yes 2 □ No	28d. Describe hov	ice 6 Other (Spec vinjury occurred	nfy)
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, deat mination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	a, and due to the cau urred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
	To the within the company of the com	M	29b. Signature and title of certifier			29c. Licens	58003	3	d. Date signed (Month	12005
6	01		30. Name and address of person who con ZEIALEM MAKOA	npleted cause of death	(Item 23a) (Type,	Print) RAVEW	Bouleva	HRD BAL	Timole, N	D 21239
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR U 8 ZUUS	A. Hogietian o c	ignature	de				

DHMH 17 Rev 1/2001

18 8 At	an	Decedent's Name (First, Middle, Vera Vera	ral White		artment of H Ditas rtificate of I hite		2. Date of Death Month 2 22	Day	Y <u>e</u> ar	e of Deat
/Media		4a. Facility Name (If not institution,		er)	4h City Town or	Location of Death		4c. County o	20.	30
Examir	ier			01)				NA	Death	
uneral		Sinai Hospi 5. Social Security Number		Age (In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthplace (Sta	te or For
irector		217-88-9815	1 □ M 2 X F	70 Yrs.	Months Days	Hours Min.	(Month, Day, 2-17-		NC	
		Usual Residence of Decedent		, , , , , , , , , , , , , , , , , , , ,			2 1/	<u> </u>		
How H		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside	
	cto	MD NA		Baltimo	re				¹ X ²Y	′es 2 [
or 21	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of WI	hat Country?	
23a		5304 Peerless				1207		U.S		
tems er r	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		 American Indian White, etc. 	Ι,
"natural", or items 23a or 28a-1 show dest Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	d 1 ☐ Yes 27 If Yes, Give Year or Date		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black	
tural	pe	15. Decedent's			edent's Usual Occupa	ation		Ch Kind of Bus		
	Completed	(Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	during most of work	king '	6b. Kind of Bus	iness/industry	
ther than	mc	Elementary/Secondary (0·12) 9th grade	College (1-4	or 5+)	Homemak	,		Ilou	~ ~	
nt th	BeC	17. Father's Name (First, Middle, La	na		nomemak		ne (First, Middle, M	Hou aiden Sumame		
		Arthur Callic	itt		j	Inez	Greenla	ъđ		
7 is marke traumatic	-	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street a				State, Zip Code)	
Tra Pr		Deborah White-	-Daughter	5304	Peerles	ss Ave.	Baltimo	ore. M	a 2120	7
item 2 other		20a. Method of Disposition	-	20b. Place of Disp					City or Town, State	
		1 ☐ Burial 2 【Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		1(9)	rematory		2/4/05 1	2altim	oro M	۲.۵
important: ff any injury or once.	1	21. Signature of Funeral Service Li			2. Name and Addres			timore,		215
E 5 8		Xala 1	March		March F.H	. West	4300	Wabash	Ave.	
-		23a. Part1. Enter the disease, or co	omplications that cau	sed the death. Do not er	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approxim	nate
sician	S 111	shock, or heart failure. List or Immediate Cause (Final	ACUI		ROIAE I	WE10-7	704/		Interval I Onset ar	
ledical		disease or condition resulting in death)	a	as a consequence of):	CLIPTE 1	ALING. I	10/0		-	
aminer	ш			ROSELEROTT	C CARDI	O VASCUC	AR OL	CASC-		
	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	V.	as a consequence of):						
25.	듣									
<u> </u>	1 2	that initiated events	C							
an and rial-tra	Examin	Cause (Disease or injury	c Due to (or	as a consequence of):						
ıysician and ne burial-traı	ical Exar	that initiated events	cDue to (or	as a consequence of):						
ng physician and s as the burial-transit	dical	Cause (Disease of injury that initiated events resulting in death) Last	c	as a consequence of);						
tending physician and r use as the burial-trai	dical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d	me of pregnancy	Ectopic pregnancy				of delivery	
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ler this certificate has been signed by the attending paratidization page 2 should be detached for use as	To Be Completed by Physician/Medical	Upper Section of Death IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	me of pregnancy 1 2 Fetal death 3 it at time of death 5 in th but not resulting in the in ENT WITH 6 I, QUSTROSIO	Other (specify) underlying cause give SDATRACTU MY TUBE	26. Place of Deal	24a. Was an autopsy perform 1 Yes 2	Montrible 2 No 3 24b. W pri pri de 10	bute to the cause of the cause	of death
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u beau. Irrector: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcon 1	me of pregnancy 1 2 Fetal death 31 1 at time of death 51 In h but not resulting in the least of my knowledge, deas of examination and/or in the least of	other (specify) underlying cause give BOATRACTU MY TUBE- nt 3 DOA Other 1 28c. Injun Work M 1 Tube th occurred at the time the occurred at the time time time time time time time tim	26. Place of Dealer. 26. Place of Dealer. 27. 4 \(\text{Nursing Hot} \) 28. Viscon to the second	24a. Was an autopsy perform 1 Yes 2 th (Check only one ome 5 Residen 28d. Describe how 28f. Location (Stre City or Town, and due to the caured at the time, dat	Monting Cook of the cook of th	bute to the cause of B Probably 4 ere autopsy finding for to completion of arth? Yes 2 No **Copecity** **To r Rural Route Note to the cause of t	gs availation cause
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		•	For State Registrar	State of M	arylan	_	artmen rtificate			and Me		giene Reg. No:	5	077	30
	Physicia	an	1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	Day	Year	3. Time of	
	/Medic	al	Margaretha Wells				45 0%	T	Location o	4 D 15	March		2005 County of Death	5:55	РМ
	Examin	er	4a. Facility Name (If not institution, give s 834 New Mark Esplan					ckvi		Death			Montgome		
	Funeral		5. Social Security Number 6. Sex	7. Ag	je (In yrs. I	ast birthday)	If Under	1 Year	If Under		8. Date of Birt	h	0 Righ	place (State o	r Foreign
ш	Director		213-36-8295	M 2∭ F	73	Yrs.	Months	Days	Hours	Min.	May 9,	193	1 Swit	zerlan	ıd
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation			-				10d. Inside C	itv Limits
	Maryli f sho	jo	Maryland Montgomen	-37		ckvill								1 X Yes	
	r 28e-	Funeral Director	10e. Street and Number	. у	ROO	CKVIII	10f. Zip	Code				10g. Citi	zen of What Cou	intry?	
	h with	al D	834 New Mark Espla	nade			20	850				Uni	ted Stat	es	
	ems;	Iner		2. Was Decedent Armed Forces?		S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spec	cify Yes or No-		14. Race - Ameri Black, White		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2X☐ If Yes, Give	No	i i	1 🗆 Yes		Specify:				Specify: Whi		
21215-0036	72 hours after death with the Maryland neturel; or items 23a or 28e-f show iteal Examitter must be motified at	ed b	15. Decedent's Educ	Year or Dates:		16a. Dece	dent's Usua	al Occupa	ation	-			nd of Business/Ir		
215	within 72 lene. than "ne the Medic	plet	(Specify only highest grade		5+)	(Give life.	kind of wo DO NOT us	rk done d se retired	turing mosi)	t of workin	g			,	
21	filed withi Hygiene. other than	Completed	12		.,	Trav	el Ag	ent					avel Age	ency	
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden	Sumame)		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan H Health and Meahal Hygiene. Health and Meahal Hygiene. Teter 71 is marked other than "neturel", or items 23a or 28e-f show other treumatic event, the Medical Examiling mast be notified at	^L	Peter Rutimann 19a. Informant's Name/Relationship (Type	ne Print)		19h Mailir	ng Address	(Street s		lie Hu		r City o	r Town, State, Zi	n Code)	
Ma	id 2 si ith an 27 is r		Susanne Weber/Nied				•					•	witzerla	-	00
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition			lace of Dispo	sition (Nan	ne of		larch	-		cation - City or T		
Baltimore,	9 = 2		1 ☐ Burial 2 X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	amoval from State	' Mor	itgómei emator	rv			2005		Betl	nesda, M	larvlan	d
alti	permit. Pag Department Importent: any injury once.		21. Signature ral Service Lic	е		22 R	2. Name an	d Addres	s of Facilit	Robe	ert A.	Pump	phrey Fu gomery A 05	neral	Home/
<u> </u>	89 2 2 2		1.36m	em.	M008)5		
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	e cause on each l	d the death ine.	n. Do not ent	er the mod	le of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximat Interval Bet Onset and	ween.
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Meta	sa		919	mo	rs Co	el c	aruno	no	L	IMO	the
	Examiner			Due to (or as	a conseq	uence of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):									
/	cuted nd ransit	Examiner	that initiated events												
30,	sate be executed oby sician and the burial-transit	EX	resulting in death) Last	Due to (or as	a conseq	uence of):									
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical													
9 X	death certifica attending ph for use as th	/Me	IF FEMALE: 22	3c. If yes, outcome	of pregna	ıncy						1 2	23d. Date of deliv	rerv	
Вох	death a atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			⊒Ectopic pr ⊒ Other (sp						Month		Year
P.O.	that the dead by the detached	hys	1 □ Yes 2 VNo 9 □ Unknown	9□ Unknown							-				
S, F	res lha igned be de	by P	Part II. Other significant conditions con	tributing to death t	but not res	ulting in the u	nderlying o	ause give	en in Part I.				se contribute to		
Records,	w requir been si should	ted				· · · · · · · · · · · · · · · · · · ·					ישו	es 2	No 31XPro	bably 4 LI	Jnknown
ec	has b	Completed									24a. Was autop perfo	sy	24b. Were auto prior to co death?	opsy findings ompletion of c	available ause of
_	T ate										1 Tes	2 No	1 Tes	2□ No	
Vital	Physicien: this certificatel director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 🗌 Inpati	ient 2	ER/Outpatier	nt 3 🗆 DC	Othe	or	of Death	(Check only o		5 ☐ Other (Speci	(6.1)	
of	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Inju	ury	28b. Time o		28c. Injury Work			8d. Describe I			197	
ion	Attending I r death. ector: After by the funer	atlo	i Natural 5 Pending investigation	(NOTAL), DE	ay roar,	пригу	М	1 🖂	Yes 2	No					
Division	or Atterder de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At ho tc. <i>(Specif</i>	ome, farm, sti	reet, factor	y, office		2	8f. Location (S City or Tox		d Number or Rur)	al Route Num	ber.
	urs af		20 0 111 20							4-1					
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Physical Examination		of examina										i)
	othin vithin o the omple	Me	29b. Signature and title of certifier	did indinoi s			290	c. License	e number			29d. Dat	e signed (Month,	Day, Year)	
			1 mend	lugle	6 n	10		P3	82	62	_	Mar	ch 7, 2	005	
	20		30. Name and address of person who co	mpleted cause of	death (Iten	n 23a) (Type,									
	<i>V</i>		Anurita Mendhirat				earch	Bou	levar	d, #3	330, Ro	ckvi	lle, MD	2085	0
• • •	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 8 2005	2. Regist	rar s Signa	IUI B	de								

			For State	State of Ma	aryland		artment o				2	005	07731
			Registrar 1. Decedent's Name (First, Middle, Las	it)		001	incate c	or Deatr		2. Date of De	Reg. No. ath	000	3. Time of Death
	Physici		Annie Selma V	allace					I	Month n	Day.	27 Year	05 6:05PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	زموي	teal	4b. City, Tow	n, or Location	of Death	ทา ใ	4c. (County of Dea	th Armdel
	Funeral Director		5. Social Security Number 6. S 241-52-1123	ex 7. Ag	e (In y s. Ia:	st birthday) Yrs.	If Under 1 Ye Months Da		or 24 Hrs. 8 Min.	Date of Birt (Month, Da May 3,	h 1928	9. Bir Ge	thplace (State or Foreign ountry) orgia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Maryi f sho	io	MD Anne Ar	unde1	G14	en Bur	nie						1 ☐ Yes 2 ☐ No
	r 28a	Funeral Director	10e. Street and Number	und 1	010	on Dui	10f. Zip Cod	e			10g. Citîz	zen of What C	
	th with	ai D	107 McGuirk Drive				2	1061			U	.S.A.	
	tems tems	ne	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13. \	Was Decedent f Yes, specify (of Hispanic C Cuban, Mexic	rigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)	. 1	4. Race - Am Black, Whi	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event. Ite Madical Evarine must be neitlised at a.	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 [X]î If Yes, Gîve Year or Dates:	No		I□Yes 2⊠						white
9	2 hou	ted	15. Decedent's Ed	lucation		16a. Deced	lent's Usual Oc	cupation	ant of working		16b. Kin	nd of Business	/Industry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest gra	College (1-4or 5	5+)	life.	kind of work do DO NOT use re	tired)	ost of working		Ша	3	
121	filed w Hygien ther th	Co	17. Father's Name (First, Middle, Last)			Tacı	ory wor		her's Name (Firms Adiabatic		dwin's	
Maryland	d be fi	o Be	"unknown"						cinda			Sumame)	
Σ	should nd Me mark	으	19a. Informant's Name/Relationship (Гуре, Print)	T	19b. Mailir	g Address (Str					Town, State,	Zip Code)
	and 2 alth a 27 is		Mrs. Mattie Field	s/guardia	n	107 M	lcGuirk	Drive	, Glen	Burni	e, M	D 2106	1
more,	of He fitem		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3	Removal from State	20b. Pla	ce of Dispo	sition (Name of natory or other	f place)	Dat	te	20c. Loc	cation - City or	Town, State
Ē	Pag tment tant: I		* 4 □ Donation 5 □ Other (Specif	<i>'</i>)	0ak		Cemeter	-	3/3/20			timore	
	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		21. Signature of Fundamental Server Licent	Dino!	3/9		Second						
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	20						rest,		Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	a		7	tive	11-4	-Crr)	+	on	Ime	Oriset and Death
	/Medical Examiner			Due to (or as	a conseque	ed ce of):							
		Jer	Sequentially list conditions, any leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	ence of						14	
V	ocuted nd transit	Examiner	that initiated events	c									
8760,	cate be executed physician and the burial-transit	E	resulting in death) Last	Due to (or as	a conseque	ence of):							
287	physi s the t	dical		. d									
Box (es that the death certific gned by the attending p be detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	су					2:	3d. Date of de	livery
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregna Other <i>(specify</i>					Month	Day Year
P.0	at the	Phys	9 🗆 Unknown										
ds,	requires that the een signed by th nould be detache	Completed by Physician/Me	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the ur	iderlying cause	given in Part	t I.	İ	obacco us ′es 2□		o the cause of death? robably 4 Unknown
Š	w require been sig should b	etec		* (24a. Was			utopsy findings available
of Vital Records,	ding Physician: The lav h, After this certificate has funeral director, page 2	ошо								autop perfor	rmed?	prior to death?	completion of cause of
tal	an: T tificat tor, pa	Be Co	25. Was case referred to medical					26. Plac	ce of Death (<u> </u>	20 No	1 🗌 Yes	25/No
—	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 E	R/Outpatien	t 3 DOA	Othon				Other (Spe	cify)
	ing Pt		27. Manner of Death ↑ Death 5 □ Pending	28a. Da e of Inju (Month, Da)	ry Year) 2	8b. Time of Injury		njury at Work?		d. Describe h	ow injury	occurred	
ivision	Attending I at death, ector: After by the funer	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		una. Al bana			1 Yes 2		f Lagation /S	Stroot and	(Alumbas as D	ural Route Number,
Ö	after after I Direct	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	ie, iaim, sir	зет, гастогу, отп	100	20	City or Tow			arar noute Number,
3	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai (29a. Certifier (Check only one)	ysician: To the best of the state of the basis of and manner sta	examination	ledge, death on and/or inv	occurred at the restigation, in m	e time, date a ny opinion, de	and place, and eath occurred	d due to the d at the time, d	cause(s) a date and	and manner as place, and due	s stated. to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier				29c. Lic	ense number		:	29d. Date	signed (Mont	h, Day, Year)
			1-	V	カリ		DH	800	6	0	7/	127	2105
	4		30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type,	Print)	tal	Av. 1	051	m	Bmi	4, mD 2106
K.	Sta	2	31. Date filed (Month, Day, Year)		ar's Signatu	re			<u></u>				
	Registr	ar	MAR 0 8 200	5 Seen	A	April	(1)						

			1 - For State Registrar	State of M	Marylan		artment rtificate					Reg. No.	400	5 0	7732
Ī	Physici	an	1. Decedent's Name (First, Middle, La	•					·		2. Date of Di Month	Day		ar	me of Death
	/Medio		Ethelyn 4a. Facility Name (If not institution, gir	Waters re street and number	er)		4b. City. 1	Town, or	Location of	of Death	3	2	2005 County of De		:40 A M
Е	LXaiiiii		Future Care Ches		,		Arno						ne Arı		
I	Funeral Director		220-36-8438	Sex 7 1 □ M 2 1 F	Age (In yrs. 96	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min	8. Date of Bi (Month, D an. 26	rth ay, Year) 5, 19	9. 8	Birthplace (S Country)	tate or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insi	de City Limits
	e-f sh	tor	MD Anne Arı	ındel	G1e	n Burn	ie							10	Yes 2∏No
	with the	Directo	10e. Street and Number 118 Roosevelt Ave	27110			10f. Zip						izen of What	Country?	
	ns 23	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	S. 13 V		061	spanic Ori	nin? (Sne	rify Yes or N	USA	14. Race - A	merican India	
036	should be filed within 72 hours after death with the Maryland of Menial Hyglene. marked other then "neturel", or Items 23a or 28e-f show imatic event. The Madical Examinat count be mailted at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 ☐ Yes 2 } If Yes, Give Year or Date:	ss? ∑No	1	fYes, speci		Specify:		cify Yes or N Rican, etc.)		Black, W	hite, etc.	311,
-	72 ho netur	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	ient's Usual	l Occupa	ition Juring most	t of workin	g	16b. Ki	nd of Busine	ss/Industry	
121	within ane. then "	mpl	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of worl DO NOT use cher	e retired))	CO WORKE	g		20 1 1		
2	filed y Hygie other f	O)	17. Father's Name (First, Middle, Las)		iea	cher		18. Mothe	er's Name	(First, Middle		. Publ	ic Sci	nools
altimore, Maryland 21215-0036	ould be Mental arked c	To B	Clarence Petitt						Este	11 Jo	hnson				
lar)	2 S 0 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1		19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street a	nd Numbe	er or Rural	Route Numb	er, City o	r Town, State	, Zîp Code)	
e)	1 and Health em 27 ther tr		Todd Waters/Grand 20a. Method of Disposition	son	20h P	120 R	OOSeV	elt					D 2106		
ğ	Ψ		1 □XBurial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Specie		ite C	emetery, cren n Have	natory or oti	her place	, ,	March 2005	-		Burni		te
<u>≡</u>	- E € € .		21. Signatur of Junera Secure Lice	9/	1010		. Name and	arĸ					1Secon		S.W.
Ö	Depar Impo any ir		1 Kal	> HOY	411	S	ingle	ton	Funer	ral H	ome, F				, MD 210
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	as a conseq	Seps	er the mode	of dying	, such as	cardiac or	respiratory a	irrest,		Approx Interva Onset	dimate il Between and Death
V	death certificate be executed e attending physicien and id for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	c	as a conseq										
09/89	tificate be ig physici as the bu	ledical		_ d											
O. Box	at the death certific by the attending p tached for use as:	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1☐Live birth 4☐Pregnant 9☐ Unknown	2 ☐ Feta t at time of d	death 3	Ectopic pre Other (spe					2	23d. Date of d Month	delivery Day	Year
S, P.	as this gned se de	by	Part II. Dther significant conditions				nderlying ca	use give	n in Part I.				se contribute		
Š	w require been sis	eted	O to	ula scr	1 air	1]No 3□		
Vital Record		Completed	0	rant a	-13-07						24a. Was auto perio 1 Yes	psy omed?	24b. Were prior to death'	o completion	ings available of cause of
Ž	Physicien: this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	ationt O	ER/Outpatien	4 2C DO	Othe			Check on				
Division of	iding Phy th. After this tuneral d	-	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of It (Month, I		28b. Time of Injury		Bc. Injury Work	at ? ′es 2 □ h	. 21	e 5 ⊔ Hesi 8d. Describe		Other (Sp.	oecify)	
DIVIS	To the Hospitel or Attending Physicien: white 24 hours elter dear Minip 24 hours seler dear Minip 24 hours or Minip 27 or the Funerel Director. After this certifica completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be determined	e 28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory,	office		21	Bf. Location (City or To	Street and wn, State,	d Number or i	Rural Route	Number,
	To the Hospit within 24 hour To the Funer completely fills	edicai (29a. Certifier 1 1 Certifying P. (Check only one)	nysician: To the be miner: On the basis and manner	of examina	wledge, death tion and/or inv	occurred a restigation,	t the time	e, date and inion, deat	d place, ar	nd due to the d at the time,	cause(s) date and	and manner and di	as stated. ue to the cau	se(s)
	To the To the Comp	M	29b. Signature and title of certifier	MA				License		21		29d. Date	e signed (Mo	nth, Day, Yea	ar)
	i		30. Name and address of person who		of death (Item	23a) (Type, I	Print) 3	350	(Asm	ilker	MD	inus 21	ch 40 229	ite :	305
	Sta Registr		31. Date filed (Month, Day, Year)	5 A2. Regi	strar's Signa	ture	W		VA ***		(

		For State Registrar	State of Maryla	and / Department of Certificate of	Health and Mental Hy Death	ygiene Reg. No 2005	07733
2		Decedent's Name (First, Middle,	Last)		2. Date of D Month	Day Year	3. Time of Death
Physic		Henry	E.	Whay	March	4, 2005	7:00 A. M
/Med Exam		4a. Facility Name (If not institution,	give street and number)	4b. City, Town,	or Location of Death	4c. County of Death	1
Exam		7701 Whays Lan	e	Pas	adena	Anne Arund	el
Funera		5. Social Security Number	6. Sex 7. Age (In y	rs. last birthday) If Under 1 Year Months Days	Hours Min. (Month, D	Day, Year) Cou	nplace (State or Foreign untry)
Directo		226-52-8092	±x ² □ F 63	Yrs.	Oct. 2	9, 1941 Vir	ginia
D >		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Location			10d. Inside City Limits
sho	5	,	Arundel	Pasadena			1 ☐ Yes 2X2XNo
he N	Directo	10e. Street and Number	. III diida	10f. Zip Code		10g. Citizen of What Cou	untry?
with	급			21122		United Stat	es
eath	era	7701 Whays Lan	12. Was Decedent Ever in		Hispanic Origin? (Specify Yes or N ban, Mexican, Puerto Rican, etc.)		rican Indian,
ter d	Funeral	1 ☐ Never Married 2 🔀 Marrie	ad litaryes 21 No	703			
Urs at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	965 1□ Yes 😥 No	Specify:	Specify: Wh	11te
1215-0036 within 72 hours after death with the Maryland one. than "natural, or Items 23a or 28a-f show then "matural to mail at the Madical Examinating the notified at	ted	15. Decedent' (Specify only highest	's Education	16a. Decedent's Usual Occi	ipation e during most of working	16b. Kind of Business/I	Industry
21215-0036 ad within 72 hours aft giene. er than "natural; or . It a Modical Erami	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir Truck Driver	e during most of working ed)	Transportat	ion
21 Mary Mary Mary Mary Mary Mary Mary Mary	Completed	0		TIUCK DIIVEI	40 Marked News /Fine Mide		
nd file	Be	17. Father's Name (First, Middle, L Earl Robert Wh			18. Mother's Name (First, Middle Gracie E. Br		
Maryland nd 2 should be file the and Mental Hy 27 is marked oth	ျ					han Circum State 1	Tin Code)
Aar 2 sh and 1s m	1 1	19a. Informant's Name/Relationsh			at and Number or Rural Route Num ane Pasadena, MI		up code)
and and lealth m 27		Katherine Whay		b. Place of Disposition (Name of		20c. Location - City or	Town, State
OF 1 OF 1 OF 1 OF 1 OF 1 OF 1 OF 1 OF 1		1 ☐ Burial 2 ☐ Cremation	3 Removal from State	cemetery, crematory or other p			
Limentent:		' 4 □Donation 5 □ Other (Sp		letro Crematory 22. Name and Add	2005	Catonsville,	, MID
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ite Mariles Examinating Item Millian at		21. Signatur of uneral Service I		17.3 - 1-1 and Day	Addal Europel Ho	ome P.A.	
		220 Part Enter the disease of	complications that caused the c	421 Crain	Hwy. SE Glen Burying, such as cardiac or respiratory	nie, MD 2106	5 1 Approximate
		shock, or heart failure. List	only one cause on each line.	1. 1. +	0-1		Interval Between Onset and Death
Physicial /Medica	_	disease or condition resulting in death)	a. Cruges		failure		days
Examine			Due to lor as soon	sequence of):	Linecuse		Monds
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence (d):	2000		100
760, C	E E	cause. Enter Underlying Cause (Disease or injury	S .	U			
oxecu n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a con	sequence of):			
. Box 68760, Cdeath certificate be executed eattending physician and eattending physician and edfor use as the burial-transit	cal		d				
68 ifficat g phy as th							
Box 68 eath certificat attending phy	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		ncv	23d. Date of del	
death	icla	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at time			Month -	Day Year
by the tache	hys	9 Unknown					the review of death?
S, P	by F	Part II. Other significent condition	ons contributing to death but not	resulting in the underlying cause	3	d tobacco use contribute to ☐ Yes 2 ☐ No 3 ☐ Pr	
cord w require been si						Yes 2 No 3 Pr	ODADIY 4 GOIKIOWII
Record he law requir he has been si	ple				24a. Wi	as an 24b. Were au	topsy findings available completion of cause of
The The age	Completed				1 Yes	orformed? death? s 2 ⊠No 1 ☐ Yes	2 No
f Vital F ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?			26. Place of Death Check onl	one	
Z × S	2	1 ☐ Yes 2 No		2 ENOutpatient 3 DOX	Other: 4 Nursing Home 5 He		city)
	, E	27. M nn Death 1 Latural 5 ☐ Pendin	28a. Date of Injury (Month, Day Yea		lork?	e how injury occurred	
Attending ar death.	catl	2 Accident investig			Yes 2 No	n (Street and Number or Ru	ural Poute Number
Division I or Attending after death. Director: Afte	Certification:	4 Homicide determ		At home, farm, street, factory, office office of the street of the stree	City or	Town, State)	3/41 1 10010 14011001,
Ditel of urs all			T the best of me	knowledge dooth see and at the	time, date and place, and due to the	he cause(s) and manner as	stated
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier 1 Certifyir (Check only 2 Medical one)	Examiner: On the basis of examiner stated.	mination and/or investigation, in m	y opinion, death occurred at the tim	e, date and place, and due	to the cause(s)
o the ithin (Me	29b. Signature and title decertifie		29c. Lice	nse number	29d. Date signed (Mont	h, Day, Year)
F ≥ 5 8			1	1	134481)	3/41	15
,		30. Name and address of person	who completed cause of death	(Item 23a) (Type, Print)	,	/ /	21061
i0		12 114	W Joseph F		1417 Madison Par	k Drive Glen	
, ,		1 1 1 1 1					
	State	31. Date filed (Month, Day, Year	32 Registrar's S	Signature			

			State of Maryland / D		artmen <i>tificat</i>				ental Hy	giene Reg. No.	005	07734
	Physici		1. Decedent's Name (First, Middle, Last) William H. Wallman						2. Date of De March	Day	2005	3. Time of Death 8:15 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Carroll Hospital Center		4b. City,		Location o			4c. (County of Death	
	Funeral Director		5. Social Security Number 216-42-2135 6. Sex 10 M 2 F 59	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da NOV •	th Year)	9. Birth Mary	place (State or Foreign ntry) / Land
0036	be filed within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Carroll Manc 10e. Street and Number 3439 Augusta Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	hes	10f. Zip Nas Deced f Yes, spec	21 lent of Hi rify Cuba 2 No	Specify:		icify Yes or No Rican, etc.)	U.	zen of What Cou S.A. 14. Race - Ameri Black, White Specify: Wh	can Indian, etc. Lte
d 21215-0036	filed within Hygiene. ther than " nt, the wea	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	(Give lite. L	dent's Usua kind of wo DO NOT us ectri	rk doné d se retired	during mos) 1		ng (First, Middle	Swee	etheart Sumame)	•
Maryland	should be tind Mental I marked o	To Be	John W. Wallman Sr. 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailir	a Addross	/Stroat			Ly Moor		Town, State, Zi	o Coda)
	la la		Patricia A. Wallman - wife 34	39	Augus	ta I	Rd. Ma	anche	ester,	Md. a	21102	
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of cemeter Cemeter Lakevi.						2005		cation - City or T esville	
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	22 C	Name and	d Addres t Fu	s of Facility nera. 1 Dr.	I Cha Mar	pel P.	A. r. Mo	a. 21102	
8760,	Physician // // // // // // // // // // // // //	ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to firm suate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the	of): of):	velu LAN Jeou)	In	Sav	etva			Approximate interval Between Onset and Death
O. Box 68	at the death certifice by the attending pt tached for use as It	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pr Other <i>(sp</i>					2	23d. Date of deliv Month	ery Day Year
Records, P.	e law requires tha has been signed ge 2 should be de	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in	the u	nderlying c	ause give	en in Part I	l. 	24a. Was	Yes 2 an psy primed?	No 3 ☐ Pro	the cause of death? bably 4 □Unknown popsy findings available ompletion of cause of
Vital	ician: certifica rector, I	o Be C	25. Was case referred to medical examiner? Hospital:			Othe			1 Yes			<i>A</i>
Division of	Attending or death. ector: After by the fune	Certification: To		Time of njury	F 2	8c. Injun Worl	4 140	No	28d. Describe	how injury	d Number or Rui	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) Certifying Physician: To the best of my knowledge (Check only one)	death	n occurred vestigation	at the tin	ne, date an pinion, dea	nd place, a	and due to the ed at the time,	cause(s) date and	and manner as s place, and due	stated. to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier			License	number	9		29d. Date	e signed (Month,	Day, Year) 7 th 2005
**	// Sta Regist	ate rar	30. Name and address of person who completed eause of death (Item 23a) ALCOLUGIA Propherson who completed eause of death (Item 23a) 31. Date filed (Month, Day, Year) 22. Registrar's Signature	Туре,		ther	الحص	hein	فيتلاء	20	1, west	7011s

		1 - For State Registrar	State	of Marylan		artment of F				giene Reg. No.	005	07735
Dhuei	.:	1. Decedent's Name (First, Middle							2. Date of Dea	Day	Year	3. Time of Death
Physic /Med					Matilda	Webster			March			5:00 A M
Exam	iner	4a. Facility Name (If not institution	•	ımber)		4b. City, Town, o		of Death			County of Death	1
		6336 Cedar Lar				Columbi		04 Usa			oward	
Funera Directo		5. Social Security Number 213-58-9982	6. Sex 1 ☐ M 2 🌠 F	7. Age (In yrs. 93	Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Day Nov 19	y, Year)	Col	nplace (State or Foreign untry) W York
		Usual Residence of Decedent		73		<u> </u>	1		NOV 19	, 191	T NE	WIOIK
yland		10a. State 10b. County	<u> </u>	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Mar B-fet	to	MD Howar	:d	Co	lumbia							1 X Yes 2 No
th the or 28;	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?
th will	a	6336 Cedar Lane	#381			21044				U.S	.A.	
r dea ems	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in U	.S. 13.	Was Decedent of In	lispanic Or an, Mexica	rigin? (Spe	ecify Yes or No- Rican, etc.)	- 14	4. Race - Amer Black, White	
illed within 72 hours after death with the Maryland Hygiene. Hygiene atterit, or items 23a or 28a-f show ant, the Marisal Examir we must be truitified at	by Fu	1 Never Married 2 Marri	If Yes, G	2 XNo ive	i	1□Yes 2XNo				9	Pannihu:	
urai'	q p	3 X Widowed 4 □ Divorced	Year or I	Dates:	1 10: 5						Wni	
nat enfici	Completed	15. Decedent (Specify only highes	s Education t grade completed,		(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	st of work	ing	16b. Kind	d of Business/I	ndustry
withii ene. than	m G	Elementary/Secondary (0-12)	College	1-4or 5+)	House		۵,			Own	Home	
filed Hygi ther		17. Father's Name (First, Middle,	Last)		House	-WIIC	18. Moth	er's Name	(First, Middle,			
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, trans.	To Be	Frederick Georg	e Kehr						lizabet			
should be nd Mental marked o	1	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street		-				ip Code)
as 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Everitims I to Item 21 and 18a-18 and 18a-18 and 18a-18 and 18a-18a-18 and 18a-18a-18a-18a-18a-18a-18a-18a-18a-18a-		Donald R. Webst	er /son		6403	3 Forest	Mill	Lane	. Laure	1. Ma	arvland	20707
F Hearten	1	20a. Method of Disposition	, , , , , , , , , , , , , , , , , , , ,	20b. P		sition (Name of natory or other place			Date		ation - City or 1	
Pages nent of h int: if ite		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (St		State		oln Cem.	1	Mar ⁵	5. 2005	Bren	-500#±	Maryland
E E E E	ė	21. Signature of Funeral Service		1	22	2. Name and Addre	ss of Facil	ity	-		ecou,	naryrana
Department of the poor of the		Wehl tolly	Vh.	M007	773 [3]	onaldson 13 Talbot	Funer t Ave	al H	ome, P. urel. M	A. arvla	and 207	07-4389
3		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat							2220	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		sepsis								Onset and Death
/Medica	i i	resulting in death)	-	(or as a conseq	uence of):							8 days
Examine	r	Coguestially list conditions	b									
₽ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):							
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с								114	
De exection and a second	ũ	resulting in death, cast	Due to	(or as a conseq	juence of):							
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d									
Box Dox Dox Beath certificate at the differ use as the different use as the diffe	Physician/Me	IF FEMALE:	23c If yes or	itcome of pregna	ancv					-		
atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	ıl death 3 □	Ectopic pregnancy Other (specify)	/			23	ld. Date of deli- Month	Day Year
that the deathed by the atte	lysic	1 ☐ Yes 2 XNo 9 ☐ Unknown	9□ Unkr		JO4111 3 [-				
that the ed by detac		Part II. Other significant condition	ns contributing to	leath but not res	ulting in the u	nderlying cause giv	en in Part	l.	23e. Did to	bacco use	e contribute to	the cause of death?
w requires that is been signed to should be detailed.	d by								1 □ Y	'es 2□	No 3□Pro	bably 4 \times Unknown
w rec	jete								24a. Was a	an	24b. Were aut	opsy findings available
he lav e has	Completed								autop	rmed? 2 X No	prior to co death?	ompletion of cause of
	a	25. Was case referred to medical					26 Place	e of Death	1 Tes		1 🗆 Yes	2L N0
ysici ysici s cer direct	o B	examiner? 1 ☐ Yes 2X No	Hospital: 1	Inpatient 2	ER/Outpatier	at 3□ DOA Oth			me 5 🕅 Resid		Other (Spec	ifv)
g Physical this neral di	n: T	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	28c. Injur Wor	v at		28d. Describe h			
ath.	atio	1 Natural 5 Pendin 2 Accident investig	ation	, , , , , , ,	,,		Yes 2□	No				
or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 Could r	ned 28e. Plac	e of Injury - At he ling, etc. (Specif	ome, farm, str	eet, factory, office			28f. Location (S City or Tow		Number or Rui	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifici completely filled in by the funeral director,								1				
Hosp 4 hou Fune ely fil	edicai	(Check only 2 Medicel	g Physicien: To th Exeminer: On the I	pasis of examina								
To the Hospital within 24 hours To the Funeral completely filled	Med	one)	and mar	nner stated.		29c. Licens	a number			29d. Date	signed (Month	Day Year)
7. wild W. D. D. D. D. D. D. D. D. D. D. D. D. D.		29b. Signature and title of certifier	, A1.	Vlan	MID				'			
		TWEE	MAN	wan	IMI	D433	<u> </u>			Marc	h 3, 20	JU5
10		30. Name and address of person Abeda Ali Khan,				Print) Ridge Roa	ad, C	Ol 11ml	oia. MD	2104	4	
9	tate	31. Date filed (Month, Day, Year)	32.	4		/	,	4110	, 110		•	
Regis		MAR 0 8	2005	lown.	J. A	acres .						

			For State Registrar		State	of Mar	ryland	-	artment of F		Mental Hy	/gier		5	07736
	Physici		1. Decedent's Name (First, CATHERI		couise	WHIT	re				2. Date of D Month Februar		eay 6, 20	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not inst 3563 Ft. Mea 5. Social Security Number	de Ro	oad #1	23	(In yrs. last		4b. City, Town, o Laurel If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bi	irth	Anne	Arui	1
poejvo	Director		578-28-7128 Usual Residence of Decede 10a. State 10b. C	ent	1□M 2 X F		92 10c. City, T			10013	01	19.	1913		10d. Inside City Limits
Glad within 70 hours after death with the Mandand	Health and Mantal Hygiene. Item 278 or 1884 or 2884 show then 278 or 2884 show other traumatic event. If a Mydical Erain set must be notified at	Funeral Director	MD Ann 10e. Street and Number 3563 Fort Me		undel Road #1		Laure		10f. Zip Code 20724			U	itizen of V		
October des	"natural", or Items 23a	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 🔀 Div		12. Was De Armed I 1 Tes If Yes, O Year or	Forces? 2⊠No Bive			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 \$\overline{\over	Specify:	(Specify Yes or N erto Rican, etc.)		Specify	k, White Whit	ie
4 CT 0141110 John 72 H	rgiene. er than "natu i, I' e Medicu	Completed	(Specify only Elementary/Secondary (C)-12)	ade completed College	1) (1-4or 5+))	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w		U: G:		l Sta	•
II y Icanica	marked oth	To Be	17. Father's Name (First, M Granville Tl 19a. Informant's Name/Rei	nomps	on			19b. Maili	ng Address (Street	Edna B	lame (First, Middle Belle Joh Rural Route Numl	nso	n		ip Code)
	Department of Health and Mental Hygene Important: If item 27 is marked other than any injury or other traumatic event, ItaMa once.		Elizabeth L 20a. Method of Disposition 1 🛛 Burial 2 🗆 Crem	ation 3 [☐Removal from		20b. Plac	e of Dispo	2 Bond Mi	се)	Date	20c.	Location -	City or 7	Fown, State
Daltin	Departmer Important any injury once.		4 Donation 5 Ot 21. Signature of Funeral Sc	-	1	hand	Mead 100160		nge Mem P 2. Name and Addre Onaldson 13 Talbot		Home P				
	hysician /Medical		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	se, or con. List only	one cause or	each line	١.		er the mode of dyir			arrest,			Approximate Interval Between Onset and Death
UNISION OF VITAL THE COURS, T.O. BOX 68/00,	physician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. Due t	yP o (or as a yP	ER consequer	TE / nce of): iPE	VSION DEMI						MANY YEARS
.C. DOA O	been signed by the attending ph should be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 gnant at ti	f pregnanc Eletal de ime of deat	ath 3	□Ectopic pregnanc; □ Other (specify) _	у				te of deli	very Day Year
colds, r	equiles inst sen signed t	by	Part II. Other significant of	RÎA			not resulti			ven in Part I.			2 No	nbute to 3 ☐ Pro	the cause of death?
אוומו חפכי	ificate has b	e Completed	25. Was case referred to n	nedical						26. Place of D	24a. Wa. auto peri 1 Yes	opsy formed?		Were aut prior to c death? 1 Yes	topsy findings available ompletion of cause of 2 No
VISIOII OI VI	to the flowership of the control of the confidence of the completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	ertification: To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 2 Accident	Pending nvestigati Could not	28a. Dal (Mo	Inpatiente of Injury	Year) 28	WOutpatien Bb. Time of Injury	f 28c. Injur Wor M 1 🗆	ner: 4 🗌 Nursing	g Home 5 Res 28d. Describe	how in		red	
NO.	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	O	4 Homicide	determine	d 289. Pla	lding, etc.	(Specify)		reet, factory, office	me, date and pla	City or To	own, Sta	ate)		ral Route Number,
1	within 24 h To the Fu	Medical	(Check only 2 Median) 29b. Signature and title of August			basis of eanner state		n and/or in	29c. Licens			29d. [Date signe	d (Month	to the cause(s) Day, Year) 2005
	10	ate	30. Name and address of page 130. Na	YEE	M.M.D.	134	ath (Item 2 50 · For's Signatur	DRT	Print) MEADE	ROAD, S	WITE 10	0,1	AUR	EL,	MD 20724
DHM	Regist	rar	MAR	08	2005	Reserved to the second	· .	4	back	<u></u>	Top Place To d				
							0	RIGIN	AL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Kuth WASKEY 03 0 2 20 1:45 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Columbia Lorien Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Date of Birth (Month, Dey, Yeer) **Funeral** Days Months Hours 1 ☐ M 2 🗓 F Yrs. July 29, Director 219-16-6672 86 1918 Maryland Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland nant of Heelth end Mentel Hygiene. Institution thems 23a or 28a-f show int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County if Heelth and Mentel Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Howard Savage 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8819 Baltimore Street 20763 U.S.A. Completed by Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 Tes 2 No If Yes, Give Yeer or Detes: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry United States Elementery/Secondery (0-12) College (1-4or 5+) Government Clerical Work 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Lest) Clarence A. Waskey Lillian Bell 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlotte Aileen Lee /cousin 8444 Foundry Street, Savage, Maryland 20763 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Savage Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/4/05 Savage, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00773 The 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Concer vectal Examiner Due to (or es a consequence of): Completed by Physician/Medical Examiner or Attending Physician: The law requires that tha daath cartificate be executed use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attanding physicien for use es the burie Due to (or as a consequence of) After this certificata has been signed by tha a funeral diractor, page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 No 25. Was cese referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Injury 1-Neturel 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital of within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 29c. License number Du053709 3/2/05 mD Koulus 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) 20716 3060 vel CLM KA5 Bowie 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar

			1 - For State Registrar	State	of Maryland	-	artment rtificate			and M			05	07738
	Physici /Medic		1. Decedent's Name (First, Midd		Ninters	3					2. Date of Dear Month February	Day	2005	3. Time of Death 11:35 AM
٤	Examin		4a. Facility Name (If not institution	gren	umber)			2	Location o	1110			y of Deeth	110
	Funeral Director		5. Social Security Number 220–30–3015	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. la 95		If Under 1	Days Days	If Under: Hours	Min.	8. Date of Birth (Month, Day, OCt 18,	1909	9. Birthi Cour Mar	place (State or Foreign ntry) yland
	Maryland f show	or	Usuel Residence of Decedent 10a. State 10b. Count MD Car	roll	10c. City,	Town or Lo	cation kesvi]	11e					1	10d. Inside City Limits 1 ☐ Yes 2☐ No
	with the ? 3a or 28e-	I Director	10e. Street and Number 7200 3rd Ave				10f. Zip		21	784	1	0g. Citizen of	What Cour	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any fulury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed I rried 1 ☐ Yes	cedent Ever in U.S Forces? s 2 X No Sive Dates:	ì	Was Decede If Yes, speci 1 Yes 2		spanic Origin, Mexican	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ack, White, fy: V	
Maryland 21215-0036	within 72 hou ene. then "nature ne Monical E	Completed by	15. Decede (Specify only highe Elementacy/Secondary (0-12)	nt's Education est grade completed College	(1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	k done d e retired)	luring most	t of work	ing	16b. Kind of E		
/land 2	uld be filed Mental Hygi irked other itic event, i	To Be Co	17. Father's Name (First, Middle Herbert Danz		rs			Cui	18. Mothe		(First, Middle, I	Maiden Suma	nalis me)	.m
	l and 2 should lealth and Men om 27 is marke her treumatic		19a. Informant's Name/Relation Susanna D. Bar 20a. Method of Disposition			2930		view		Caz	al Route Number adero, (421	
Baltimore,	permit. Pages Department of Importent: If ite any injury or of once.		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Specify)	n State Cel	metery, cřei	matory or oth	her place				EGG. EGGGHOTT	- 01.9 01 10	owii, Siaio
Ba	permi Depa Impo any ia		21. Signature Cuneral School 21. Signature RODA 1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	or complications that	caused the death.	Ba	tate A altimo	nato re,	omy B	oard 2120			nore S	Approximate
7	Physician /Medical		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	o (or as a conseque	ence of):	Pre	m	oniz	_				Interval Between Onset and Death
	icate be executed XX physician and XX s the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a conseque									
P.O. Box 68	Attending Physicien: The law requires that the death certifica rdeath. cetor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	outcome of pregnan birth 2 Fetal of gnant at time of dea known	death 3[⊒Ectopic pre ∃ Other <i>(spe</i>					1	ate of delive	ery Day Year
	quires that I n signed by uld be deta		Part II. Other significant condit	ions contributing to		r .	nderlying ca	use give	n in Part I.		23e. Did tob			he cause of death?
Division of Vital Records,	The law requir cate has been si page 2 should i	Completed									24a. Was a autops perform	v /	prior to co	opsy findings available mpletion of cause of
f Vita	nysicien: nis certific director.	To Be	25. Was case referred to medic examiner? 1 Tyes 2 No	Hospital: 1	☐Inpatient 2☐E	R/Outpatier	nt 3 🗆 DO/	Othe	r /		me 5 ☐ Reside		her (Specif	(y)
sion o	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	Z	tigation	e of Injury onth, Day Year)	28b. Time o Injury	f 28	c. Injury Work 1 🗆 Y	at ? ∕es 2 □ !	No	28d. Describe ho			
Ď Ž	Hospitel or Attending I 24 hours after death. Funerel Director: After tely filled in by the funer		4 Homicide deten	mined 286. Pia	ce of Injury - At hon Iding, etc. (Specify)					ļ	28f. Location (St City or Towr	n, State)		
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	(Check only 2 Medica one)		he best of my know basis of examination anner stated.	rledge, deat on and/or in	vestigation,	in my <i>o</i> p	oinion, deal	d place, th occurr	ed at the time, da	ate and place,	and due to	the cause(s)
)	To the within To the comple	×	29b. Signature and title of certifi	Jonn(7	2			number 0599	143		9d. Date signe		3, 2005
			3	1 MO 29	s Stone	AV	Print)	ite	307	W	estmin:	Ster,	MD	21157
	Sta Registi		31. Date filed (Month, Day, Yea.	8 2005	gistrar's Signatu	Tre	1000							

			Type or Print State of Mar					-	-	effs. 17709	07739
		1 - For State Registrar				tificate of L		-	Reg. No.	100	01103
Physici	an	Decedent's Name (First, Middle, Las	it)					2. Date of De Month	Day	Year	3. Time of Death
/Medic	al	Patricia Wiley 4a. Facility Name (If not institution, give	street and number)			4h City Town or	Location of Death	Februa		2005 nty of Dea	
Examin	ier	Joseph Richey H					timore		40.000	illy of Dea	
Funeral Director		5. Social Security Number 6. Se		in yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct 5,	ly, Year)	Co	thplace (State or Foreign ountry) rginia
g		Usuel Residence of Decedent		o. o				,			
show	2	10a. State 10b. County	'	oc. City, 1	own or Lo	cation :imore					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M	Director	10e. Street and Number			рат	10f. Zip Code			10g. Citizen o	of What Co	Λ –
3a or	10	1102 Druid Hill	Avenue #13	0.5			21201				ountry:
death ms 2	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. V	Was Decedent of Hi f Yes, specify Cuba		cify Yes or No	US/ - 14. B	ace - Ame	encan Indian,
or Ite	y Fu	1 ☐ Never Married 2 🕅 Married	1 ☐ Yes 2 XNo		i.	Tes, specify Cuba	Specify:	rican, etc.)	Spe	llack, Whit	
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nin 72 n na n na	piet	(Specify only highest grade Elementary/Secondary (0-12)	de completed)		(Give	kind of work done of DO NOT use retired,	luring most of worki	ing	16b. Kind of	DUSINASS	inoustry
giene grene er tha	Completed		College (1-4or 5+) ink			housewi:	fe 		own	home	
should be filed within 72 hours after death with the Maryland not Mental Hygiene. In marked other than "naturel", or Items 23a or 28a-f show marked other than "naturel", or Items 23a or 28a-f show umatic event, the Medical Examinar must be notified at	To Be (17. Father's Name (First, Middle, Last)				unk	18. Mother's Name	(First, Middle,	, Maiden Sum	ame)	unk
shoul and Mark amark	۲	19a. Informant's Name/Relationship (7	ype, Print)	1	19b. Mailin	g Address (Street a	and Number or Rura	l Route Numbe	er, City or Tow	vn, State, 2	Zip Code)
1 and 2 Health a tem 27 is		William Carter/sp				Druid Hi			Baltim	ore,	MD 21201
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Items 23a or 28a-1 show any injury or other traumatic event, the Markical Examinat must be notified at ance.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ⚠ Other (Specify	Removal from State			sition (Name of natory or other place	9)	Pate	20c. Locatio	n - City or	Town, State
permit. Departn Importa any inju		21. Signature of Funeral Service Licent RONAL	Wade, Tree	tor	St Ba	Name and Addres ate Anato 1timore,	s of Facility DMY Board MD 2120	655 W.	Balti	more	Street .
Physician /Medical		23a. Part Enter the disease, of compshock, at heart failure. List only of immediate Cause (Final disease or condition resulting in death)	one cause on each line.	lasta	hic !	er the mode of dying		r respiratory ar	rrest,		Approximate Interval Between Onset and Death
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ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury)	Due to (or as a c	onsequen	ce of):						
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 27 to the Funeral Director: After this certificate has been signed by the attending physicis To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tim 9 Unknown	Fetal dea	ath 3 🗌	Ectopic pregnancy Other (specify)				Date of deli Month	ivery Day Year
as that gned b	by P	Part II. Other significant conditions co		ot resultin	g in the un	iderlying cause give	n in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?
require een si	ted	Diabetes	mellitus					1 🗆 Y	res 2 No	3 🗆 Pr	obably 4 Unknown
The law cate has b page 2 si	Completed							24a. Was autop perfor	an 24b osy rmad? 2 2 No	prior to death?	topsy findings available completion of cause of
nysician: Th	Be	25. Was case referred to medical examiner?	Hospital:			040	26. Place of Death	(Check only o	ne)		
Physic this cral direct	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury		Outpatient	28c. Injury	4 Nursing Hon	ne 5 Resid		ther (Spec	elly) Hospice
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tal or Att s after d al Direct ed in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, Specify)	, farm, stre	eet, lactory, office	2	281. Location (S City or Tow		nber or Ru	ral Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai (29a. Certifier 1 ☐ Certifying Phy (Check only one)	vsician: To the best of n inar: On the basis of ex and manner stated	amination	dge, death and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the ded at the time, d	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
To the To the comp	ž	29b. Signature and title of certifier	M mo			29c. License	/		29d. Date sigr		
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State Registrar

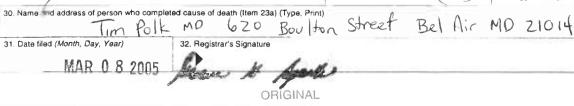
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2-22-05

Attain (Wiley Exp. Red Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

MAR 0 8 2005



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a&25 per me G842 4-7-05 tas
State of Maryland / Department of Health and Mental Hygiene 1- State Amended 23a, 25, 2/22/05, LDB, DORCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year Anthony Thomas Arroyo 2005 /Medical 02 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Peninsula Regional Medical If Under 1 Year If Under 24 Hrs. Centel WILLANICO 8. Date of Birth (Month, Day, Year) Jan. 22,1917 5. Social Security Number 9. Birthplace (State or Foreign Country) Puerto Rico 7. Age (In yrs. last birthday) **Funeral** Months 1. M 2□ F Days Hours Min. Yrs 186-10-0635 Director 88 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show The Modical Examiner must be notified at 10d. Inside City Limits Director Maryland Wicomico Delmar 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9005 Williams Mill Pond Road 21875 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Puerto Rican þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 nd 2 should be filed within 7 sith and Mental Hygiene.
27 is marked other than "n r traumatic avant, I're Man Elementary/Secondary (0-12) College (1-4or 5+) Tool Designer Aircraft Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked c any injury or other traumatic av. since. Anthony Arroyo Maria Marquez ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelina M. Arroyo/Wife 9005 Williams Mill Pond Road, Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State ` 4 ☐ Donation 🐬 ☐ Other (Specify) Crematory of Delmarva 2/16/2005 Delmar, Delaware 21. Signature of Funeral Service Zeller Funeral Home, P. O. Box 3171, 1212 Old Ocean City Road, Salisbury, MD 21802 ngêe Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List doily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** GERP Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed UWL Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) Ö 9 Unknown ģ ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Coronam arten 1158950 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? upper Osi certificate Weed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; After 28d. Describe how injury occurred 5 Pending 1 PNatural 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funaral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 140059368 men npleted cause of death (Item 23a) (Type, Print) Carrollst Salichum MD 100 G John 1815/1 Mul 31. Date filed (Month, Day, Year) State FEB 22 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. U 2. Date of Oeath 1. Decedent's Name (First, Middle, Last) Fah **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner SALISBURI THE A+ Wicomido Hospice OASTAL If Under 1 Year | If Under 24 H/s 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 178 M 2□F 65 Jan. 16,1940 Maryland Director 217-36-2255 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28e-f show treumatic event, the Medical Examinational Landillied at 1 ☐ Yes 2 2 No MD Dorchester Elliott Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5 Pages 1 and 2 should be filed within 72 hours after death with 2332 Elliott Island Road 21869 USA items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) waterman seafood 10 other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Winnie Abbott Dorothy Robbins ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 Teresa Abbott wife 2332 Elliott Island Rd., Elliott, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 1 Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If any injury or once. Elliott U. M. Churchyard 2/22/05 *4 □ Donation 5 □ Other (Specify) Elliott, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Dealt Immediate Cause (Final disease or condition resulting in death) Centretil Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physiclan/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 🗆 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has b director, page 2 s autopsy performed 2 No 1 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 atient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗀 Yes 2 ER/Outpatient 3 DOA this 27 Manuer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

State Registrar

DHMH 17 Rev 1/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 2 2005

0.0

32. Resstrar's Signature

PAULOCOLAIN

31. Date filed (Month, Day, Year)

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month George William Addison Feb. 16, 2005 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton P.G. If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 2-22-30 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F 291-26-9920 74 Director Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show in than "neturel", or Items 23a or 28e-f show the Medical Exercises must be notified at Md. P.G. Temple Hills Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7202 Westchester Drive 20748 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Syes 2 No If Yes, Give Year or Date**Korean** 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 夕 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) 2+ Elementary/Secondary (0-12) Real Estate Broker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental William Addison, Jr. injury of other traumatic Lydia Sandridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 Department of Health a Important: If item 27 Is any injury or other training once. Phoebea Addison/Wife 7202 Westchester Dr. Temple Hills, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Arlington Nat. Cem 3/2/05 Arl., Va. 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LORONARY ARTERY Priysician /Medical Examiner ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached fo Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3☐ DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospitel o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Komero D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID MARIA ROMERI 31. Date filed (Month, Day, Year) FEB 2 indapolis, State 2005 Registrar

Ame Ame	ended 7,pe nded,8, p	er er	F.H., TCHD, 02/28/0 1- State F.H., TCHD	05, State of Mar 0,02/22/2005,s	yland / Desbb	epartment of F Certificate of the	leaith and Me <i>Death</i>	ental Hygi	ng () 5 ()7743
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	Exami		4a. Facility Name (If not institution,			~	r Location of Death		4c. County of Deat	
			Memorial Ho		(In yrs. last birtho	EQSTOR		Data of Bigh	Talbot	
	Funera Director		5. Social Security Number 219–16–3748	1 M 2 F	91- 79 Yrs		Hours Min.	B. Date of Birth (Month, Day, Y	1923 MAR	hptace (State or Foreign untry) YLAND
			Usual Residence of Decedent					arch 6,		
	arylar	5	10a. State 10b. County		IOc. City, Town o					10d. tnside City Limits 1√2 Yes 2 □ No
	with the Maryland a or 28e-f show	Directo	MARYLAND TA	ALBOT	EAS	10f. Zip Code		100	. Citizen of What Co	
	23a or		610 DUTCHMAN	S LANE		21601	L	log	U.S.	untily?
	Baltimore, Maryland 21215-0036 Demit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23 my njury or other treumatic event, the Madical Extendition and	sted by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent's	tf Yes, Give Year or Dates:	16a. De	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No seedent's Usual Occup	n, Mexican, Puerto Ri Specify: ation	ican, etc.)	14. Race - Ame Black, White Specify: WHI b. Kind of Business/	e, etc. TE
90	nd 21215- s filed within 72 ! Hygiene. other than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lit	e. DO NOT use retired PHONE OPER	3)		OMMUNICAT	TONS
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9	re, Marylances tand 2 should be to the and Mental before the and Mental before 27 is marked of other treumatic events.	1	19a. Informant's Name/Relationshi			ailing Address (Street a				lip Code)
	ore, Mass 1 and 2 of Health 3 item 27 is other tre		SALVADOR F. BIO	ONDO /SON		BOX 207	PRESTON,		5 c. Location - City or	Tour State
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٢	Balt permit, Departr Import eny inj		21. Signature of Funeral Service L		58		NELFENBEIN RRISON STRI		NAM FUNER STON, MD	AL HOME, P.A
	68760, Physician and Bunsician as the burial-transit as the burial-transit	Examiner	shock, or heart faiture. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. URO Due to (or as a c	consequence of):	IS				Interval Batween Onset and Death
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	Division of Vital Records, or Attending Physicien: The law requires talter cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be or a factor or a factor or a factor.	Completed						24a. Was an autopsy performed	d? prior to death?	topsy findings available completion of cause of
	Vital Ficien: The certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death (Check only one)		
	of Vita Physicien: this certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient			4 Indising Home		e 6 Other (Spec	ify)
	Vision C Attending F r death. ector: After by the funera	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	ation	/ear) 28b. Tim Injui	y Work	/ at 28 <br Yes 2 □ No	d. Describe how	intury occurred	
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	Divisit To the Hospital or Attan. within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physician: To the best of a xaminer: On the basis of examiner and manner states	xamination and/o	eath occurred at the fir r investigation, in my op	ne, date and place, and pinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier Filsus	Isis"		29c. License	9 number 59487		Date signed (Month) 2/21/05	_
			30. Name and ordess of person w	ho completed cause of deal		oe, Print)				
	and the same of th	ate	JOHN BOTSIS 1 31. Date filed (Month, Day, Year) FED 2 2 2	3 Registrar's	S. WASI s Signature	HINGTON ST.	, EASTON,	MD 2160	1	
	Regist		FEC 6 6 21	101	IS. A	mil!				

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar 077 ls ls Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Louis Marvin Buckle February 21 /Medical 2005 3:00 A M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ruxton Health Denton Caroline If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**X** M 2□F Months Director 217-30-8908 Vrs 70 Oct 22 1934 Maryland Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28e-f show The Madical Exergirer must be notified at Directo 1 ☐ Yes 2X No Maryland Caroline 11522 Holly Road Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11522 Holly Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after t Hygiene. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes ŽXNo ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier importents: If Item 27 is marked other th any Injury or other treumetic event, the ance. 11 truck driver food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Reuben Buckle Eva Tribbitt Buckle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Blunt Buckle/ wife 11522 Holly Road Ridgely, Maryland 21660 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Chesapeake Cremation | Feb. 26 2005 Chester, Maryland 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, MD 21639 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Fallure 14000 /Medical Due to (or as a consequence of): **Examiner** o to lor as a condition of archer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical as attending use IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 Tyes 2 No 3 Probably 4 Unknown peen The law 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has certificate 1 Yes 2 🗆 No 2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne Death After Medical Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 1 atural 5 Pending efter death.

I Director: Aff investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funerei D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0061688 02/22/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUPAL R. DESAI 9108 DIDONATO DRIVE CHESTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 3 2005 Registrar 2016

Henry Coxe BRINTON Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. E	insure All Copies Are Legible.
State of Maryland / Department of Hea Certificate of De	alth and Mental Hygiene 05 07745
(First, Middle, Last) HENRY C. BRINTON	2. Date of Death Month Day Par 13. Time of Death 2005 12:55A

			1 - For State Registrar	,,,,,	Cei	tificate of	Death		Reg. No.	0 01140
	Physici	20	1. Decedent's Name (First, Middle, Las	t)				2. Date of D	eath Day	Year 3. Time of Death
	Physici /Medio		HENRY	C. BRINTO	N			Febru		2005 12:55A M
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	h	4c. County	of Death
			DOCTORS COMMUN		to an fair-th down	If Under 1 Year	ANHAM If Under 24 Hrs	1		NCE GEORGES
L	Funeral Director		103-20-0390	7. Age (In yrs. 70	Yrs.	Months Days	Hours Min.	(Month. D	ay, Year) 15,1935	9. Birthplace (State or Foreign Country) PA.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or Lo	cation				10d. Inside City Limits
	Aarylan f show	ъ			,,					Y Yes 2 □ No
	or 28a-f	Director	MD. PRINCE (SEORGE 5		BOWII	L		10g. Citizen of V	What Country?
	3a or	٥	6206 GIDEON S	ייי		9	0720		2.2 (4)	5.A.
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. \	Was Decedent of H	lispanic Origin? (S	pecify Yes or N	o- 14. Rac	e - American Indian,
ထ္	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		fYes, specify Cuba I□Yes 2 X No		o Hican, etc.)		ck, White, etc.
93	172 hours after death with the Maryland "naturel", or Items 23a or 28a-f show idical Examinations be invitibed at	d by	3 Widowed 4 Divorced	Year or Dates:		A 140	Specify:		Specify	WHITE
21215-0036	"natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	(Give	lent's Usual Occup kind of work done	during most of wor	rking	16b. Kind of Bu	usiness/Industry
12	within ene. than "	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	,		NA GA	
	Hygie Hygie ther	e Co	17. Father's Name (First, Middle, Last)	4		PHYSICIST		ne (First, Middle	NASA Maiden Sumam	
an	ould be Mental arked o	To B	HENRY L.	BRINTON					E. COX	
Maryland	i 2 should be filed within n and Mental Hygiene. Te marked other than raumatic event, Ibe M	-	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street				
	1 and 2 Health a tem 27 le		MARY LORAINE BRIN	TON/WIFE	6206	GIDEON S	ST., BOWI	E. MD.	20720	
) Š	item item		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place		Date		City or Town, State
<u>E</u>	nit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla narment of Health and Mental Hygiene. ortant: If item 27 le merked other than "naturel; or items 23e or 28a-f show injury of ortant: Item Medical Examinations to the injury of ortant.		1 ☐ Burial 2 ★ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		S CREMATO		-2005	RIVERD	DALE, MD.
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce.		21. Signature of Funeral Service Incent		22	. Name and Addres	ss of Facility			
-	20 = 2 2		MM Cha	Meur MOO	091 5	HAMBERS I 801 CLEVE	ELAND AVE	RIVE	RDALE, M	D. 20737
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	n. Do not ente	er the mode of dyin	ig, such as cardiad	or respiratory a	ırrest,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequence	uence of):		0 0	cer	J	
		-	Sequentially list conditions,	b. Due to (or as a consequ	lence of	70	can	Cer		
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,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):					
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Вох	The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Estania aragana			23d. Date	e of delivery
	deat	sicia	in the past 12 months? 1 Yes 2 No	1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown		Ectopic pregnancy Other (specify)			Mor	nth Day Year
P.0	at the de by the stached	hys	9 🗌 Unknown							
	es tha igned be det	Completed by Physician	Part II. Other significant conditions co	entributing to death but not resu	ulting in the un	derlying cause give	en in Part I.			ibute to the cause of death?
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e C	e law has b	nple						24a. Was	psy p	Vere autopsy findings available rior to completion of cause of
<u>=</u>		Con						perfo 1 ☐ Yes	ormed? d	eath? ☐ Yes 2 ☐ No
/ita	siclen: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Useralist			26. Place of Dea	th (Check only o	one)	
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	ding I h. After funer	lon	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/at k? Yes 2 □No	28d. Describe	how injury occurre	ed .
Division	or Attendi after death. Director: A in by the fu	ical	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me farm stre		162 5 140	28f Location (Street and Number	er or Rural Route Number,
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_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier i Certifying Phy	sician: To the best of my know	wledge, death	occurred at the tim	ne, date and place	and due to the	cause(s) and mar	nner as stated.
	ne Ho n 24 h ne Fui	edical		iner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my or	pinion, death occur	red at the time,	date and place, a	and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	100		29c. License			1	(Month, Day, Year)
	(3	The Talent	MA		2000	5844	16	02/2	10/2005
	J		20 Nametand address of devens who d	ompleted cause of death (Item	020) (T					1

30. Name (and address of derson who completed cause of death (Item 23a) (Type, Print)

Nad Fh Zda Koud Chuk, MD 8118 food Lulk Rd Lonham Md 20706

31. Date filed (Month, Day, Year)

FEB 2 2 2005

Security of parks. State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere [] [] 5 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9:30 a John Andrew Bowen February 19,2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 XM 2 ☐ F Yrs. 215-68-8636 49 16, 1955 Washington, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24808 Frederick Road 20871 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Master Electrician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Earnest Bowen Rita Evelyn Archangel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rita Evelyn Bowen/ Mother 1705 Florin Street, Silver Spring, MD 20902 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition February 24 cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 5 Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Faneral Service Ligenses 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metasianic Due to (or as a consequence of) 21054011e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 22No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

in then "natural", or items 23e or 28e-f show The Medical Examinat must be motified at

within 72 hours after

al Hygiene.

permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: if Item 27 is marked other th
any injury or other traumatic event. Its

Baltimore, Maryland 21215-0036

Directo

Examine

attending physician and for use as the burial-transit use as 1 ned by the atter page 2 should

Physician/Medical Completed by Be Certification: To

After this certificate or Attending Physician: funeral director. To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completely filled in by the fune

Records, P.O.

19.05

John N

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending

3 🗌 Suicide 4 Thomicide 29a. Certifier

(Check only one)

29b. Signalu

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year) 29c. License number 2153 eb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11510 Old Georgetown Rd., Rockville, MD 20852 Gabriel Peter Pushkas, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) 2005



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DP			1. Decedent's Name (First, Middle,		<u></u>	Oeri	incate of	Dealii			Reg. Neath2-	11-2005	3. Time of Death
	Physici		RICHARD KO	OFI BOTCH	WAY				1	Month FFRRIIA	C	10, 2005	
	/Medio Examir		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	or Location o	f Death		14	c. County of Dea	
			PRINCE GEORGES H				CHEVER					PRINCE G	EORGES
	Funeral Director		5. Social Security Number 229.29.4250	. Sex 7. Ag 1⊠M 2□F	e (In yrs. last b 21	Yrs.	If Under 1 Year Months Days		Min.	B. Date of Bir (Month, Da	iv. Yea	9. Bir	thplace (State or Foreign
			Usual Residence of Decedent							May 13	5, 1	1983 Was	hington, DC
	show	_	10a. State 10b. County	_	10c. City, To	wn or Loc	ation						10d. Inside City Limits
	Ba-f s	Director	Maryland Prince	George's	New	Carr	ollton						1 TYes 2 □ No
	with t		10e. Street and Number 5910 89th Avenu				10f. Zip Code				10g. C	Citizen of What C	ountry?
	death ms 23	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	20784		in? (Spec	ify Yes or No)-	U.S.A. 14. Race - Am	erican Indian
9	or Itan		1⊠ Never Married 2 ☐ Married	Armed Forces?			as Decedent of H Yes, specify Cub		Puerto P	ican, etc.)		Black, Whi	te, etc.
203	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			☐ Yes 2⊠ No	Specify:				Specify: B	Lack
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21215-0036	be filed within 72 hours efter death with the Maryla ital Hygiena. of other than "natural", or frams 23a or 28a-f show of other than "natural", or frams 23a or 28a-f show of other than "natural" and itled at	Completed	Elementary/Secondary (0-12)	College (1-4or 5 1 Year	5+)		tudent	(40)			В	Barber So	chooling
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ylar	2 should be filed within 72 hours efter death with the Maryland end Mental Hygiena. Is marked other than "natural", or Itama 23a or 28a-f show eumatic event, I'm Medical Exament must be notified at	ToE	Samuel Botchwa	У				Albe	ertin	a M.	Od	lonkor	
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Baltimore,	ages int of		1 Burial 2 □ Cremation 3				tion (Name of atory or other pla Nat '1					Location - City or	
量	ortan injur		 4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lip 	**	milli			1				-	Virginia
ä	Per Imp		Nancy A.	Parantie		HI	Name and Addre NES-RIN 800 New	ALDI F Hamps	UNER hire	AL HOM	E Sil	INC. ver Spri	ng, MD 2090
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9 ×	eeth certifica attending pl	Med	IF FEMALE:	00. #									
Вох	seth c attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal deat		ctopic pregnancy	у				23d. Date of de Month	ivery Day Year
P.O.	thet the de ed by the a detached	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	time or death	5 🗆 (Other (specify) _						,
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rds	w require been sig should b									1 🗆 Y	es 2	2 X No 3□Pr	obably 4 Unknown
ecc	e law re has be	Completed								24a. Was		24b. Were au	utopsy findings available
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Division of Vital Records,	g Physier this	۲. To	1X Yes 2 No 27. Manner of Death	1 ☐ Inpatie	nt 200 ER/0	utpatient Time of	3 DOA Oth	4 LI Nuis		d. Describe h		6 Other (Spe	cify)
io	nding lath. r: After e funer	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day		Injury		rk? ∣Yes 2 ,5⊘ N				eval SHCT	
<u>×</u>	r Attendi er death. rector: A by the fu	tiffica	3 ☐ Suicide 6 ☐ Could not determine	be On Diagrandia				(found)	28				ral Route Number,
D	Itel or rs aft rel Di led in	Cer		Daliding, etc		ventch						H MD	a tripage
	he Hospitel or Attendii n 24 hours after death. he Funerel Director: A pletely filled in by the fu	Medicai	29a. Certifier Certifying I (Check only one)	Physician: To the best of aminer: On the basis of	examination a	je, death o nd/or inve	occurred at the tir stigation, in my o	me, date and opinion, death	place, an	d due to the o	cause(:	s) and manner as	stated. to the cause(s)
	To the Hospitel or Attending Physician: The law requires thet the deeth certificate be within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Mec	29b. Signature and title of certifier	and manner sta			29c. Licens					ate signed (Monti	
	- s + ō			V. 114			OCM					BRUARY 1	**
	4		30. Name and address of person wh	o completed cause of d	eath (Item 23a)	(Type, Pr		<u>u</u>					
-			JACK	1. Titus M	1.D.			nn Str	eet I	Baltimo	ore.	, Maryla	nd 21201
	. Sta Registr		31. Date filed (Month, Day, Year) FEB 22	2005 32. degistra	ar's Signature	600	de					,	

		,	For State Registrar		State o	f Ma	rylan				lealth a		ental Hy	giene Reg. No	6	005	0	774
		29	1. Decedent's Name (Fir	rst, Middle, Las	t)								2. Date of De	ath			3. Time of	f Death
	Physici /Medio		Hedwig Be	1in									Feb.	13,		Year D	9:45	\mathbf{p}^{M}
	Examir		4a. Facility Name (If not	institution, give	street and nu	mber)			4b. City	, Town, or	Location	of Death		4c.	. County o	of Death		
		8	Manor Care						Poto		I I I I I I I I I I I I I I I I I I I	0411		Me	ontgo			
- 1 - 40	Funeral Director		5. Social Security Number 081.32.5682		9X □M 2 X 2F	7. Age 88		last birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month Da 0ct • 15	th 19, Year)	16	9. Birthp New	lace (State of York	or Foreign
	p ,		Usual Residence of Dec				10- 0:5	. T			-					Т.		
	shov	7		o. County	7477		-	y, Town or Lo	ocation							1	0d. Inside C	ity Limits 2 \Begin{align*} No
	28a-f	Director	MD Me	ontgome	ГУ		Pot	omac	104.7	0-4-				10- 0'				
	with a	D								0854					izen of W	hat Cour	itry?	
	ns 23	era	10714 Poto	mac rei	12. Was Dece	edent E	ver in U.	S. 13.	Was Dece	dent of Hi	ispanic Ori	igin? (Spe	city Yes or No	USA -	14. Race	- Americ	an Indian,	
S	or Iter	by Funeral	1 Never Married	2 Married	Armed Fo	mces?			If Yes, spe	cify Cuba	n, Mexicar	n, Puerto F	Rican, etc.)		Black	, White,	etc.	
<u> </u>	rel', o	l by	3√□ Widowed 4 □	Divorced	1 XYes If Yes, Gir Year or D	ve I Z -	31-:	1346	1 🗆 Yes	21 X No	Specify:				Specify:	Whi	te	
2-0	72 h	Completed		Decedent's Ed	ucation			16a. Dece (Give	kind of w	ork done d	during mos	t of workin	ıg	16b. K	ind of Bus	siness/In	dustry	
7	within ne. then	mp	Elementary/Secondar	y (0-12)	College (1-4or 5+	-)		DO NOT	ise retired)			TIG				
() ()	Hygie Hygie ther I	e Co	17. Father's Name (First	t. Middle, Last)	4+			Lt.	COT		18. Mothe	er's Name	(First, Middle		Army			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23s or 28a-f show amy injury or other treumettic event, the Medical Exam har must be notified at ance.	To Be	Frank KadJ		i								e Weso			′/		
Ž	shoul nd Me mari	1	19a. Informant's Name/					19b. Maili	ng Addres	s (Street a		-	Route Numb			State, Zip	Code)	
Š	nd 2 alth a 27 is	1	Henry Cadel	.1/Broth	ier								otomac					
Baltimore,	ss 1 a		20a. Method of Dispositi		5	<u> </u>	20b. P	lace of Dispo	osition (Na	me of other plac	e)	Da	ate	20c. Lo	ocation - C	City or To	wn, State	
Ĕ	Page Internal Page		1 ☐ Burial 2 ☐ Cre 1 ☐ Donation 5 ☐			State		. Comf	-	•	· 1	2-28	-05	Alex	andri	ia, '	VA.	
alt	spartr spartr sport ny inj		21. Signature of Funeral	Service Licen	S00								ph Gaw					
	207 2 2		Crup	1	MO137			51	30 Wi	scon	sin A	lve.	N.W., 1	Vash	ingto	on Do	200	16
С			23a Part 1. Enter the dis shock, or heart fail		olications that one cause on e	aused to	he death	n. Do not en	ter the mo	de of dyin	g, such as	cardiac or	respiratory a	rrest,			Approximate Interval Bet Onset and leading	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	1	a. Strok	e											Oriset and	Death
	/Medical Examiner		rosuming in death)	ſ	Due to	(or as a	consequ	uence of):										
		-G	Sequentially list condition	ons, diate	b. Due to	(or as a	consequ	uence of):										
	uted d ansit	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	y 🔨														
Ó	exec an an rial-tr	Exa	resulting in death) Last	- 1	Due to	(or as a	consequ	uence of):										
8760,	ficate be executed physician and sthe burial-transit	dlcal			d													
9	ing ph a as t	Med	IF FEMALE:											T				
Вох	eath certifi attending i for use as	lan/	23b. Was decedent preg in the past 12 mon		23c. If yes, out	pirth 2	Fetal	death 3	Ectopic p					1	23d. Date Mont		•	/ear
0	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by Physiclan/Me	1 ☐ Yes 2X No 9 ☐ Unknown		4∐Pregr 9∐Unkn		ime of de	eath 5	Other (s	oecify)							,	
<u> </u>	uires that the de signed by the a Id be detached f	H.	Part II. Other significant	t conditions co	ontributing to de	eath but	not resu	ulting in the u	nderlying (cause give	en in Part I	,	23e. Did t	obacco (use contrib	oute to th	e cause of d	leath?
ds,	uires r sign lld be		Dementia										10	res 2	∑ No 3	B 🗆 Prob	ably 4 □L	Jnknown
00	s been si should I	lete											24a. Was	an	24b. W	ere autor	osy findings	available
Vital Record	The lav	Completed												rmed?	pri	or to cor ath?	npletion of ca	ause of
ta		0	25. Was case referred to	o medical							26. Place	of Death	1 Tes	2LXNo		Yes	2 L NO	
<u>_</u>	S 0 10	To B	examiner? 1 ☐ Yes 2√ No		Hospital: 1 🗆	Inpatien	t 2 🗆 1	ER/Outpatier	nt 3 🗆 D	Othe	or.		e 5 ☐ Resi		6 🗌 Other	(Specify	')	
n 0	ding Phy h. After thi funeral	on:	27. Manner of Death 1X Natural 5	Pending	28a. Date (Mon	of Injury th, Day	Year)	28b. Time o	f	28c. Injury Work	at ?	21	8d. Describe l	now injur	y occurre	d		
Sio	r Attendi er death. rector: A by the fu	cati	2 Accident	investigation Could not be					М		Yes 2		061					
Division of	i Şi fi	Certification:	4 Homicide	determined	280. Place	of injui	y - At no (Specify	me, farm, sti	reet, factor	y, office		2	8f. Location (S City or Tox	vn, State	a Number)	r or Hura.	Houte Num	ber,
_	Hospitel or Attendir 24 hours after death. Funerel Director: Aftely filled in by the fur	al Ce	29a. Certifier X	Certifying Ph	ysician: To the	best of	my know	wledge, deat	h occurred	at the tim	ie, date an	d place, ai	nd due to the	cause(s)	and man	ner as st	ated.	
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	edical	(Check only 2 one)	Medicel Exem	niner: On the b and man	asis of e	examinat	tion and/or in	vestigation	i, in my op	oinion, dea	th occurre	d at the time,	date and	place, ar	nd due to	the cause(s)
	To I To I	Σ	29b. Signature and title	of certifier	MM	D			29	c. License		521	15	29d. Dat	te signed	(Month, i	Day, Year)	
}	25		A	rain	٠ ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ، ،	-				り		536	1)	Feb	. 15,	, 200)5	
	4		30. Name and address of				,		,	#00	0 5	,	11		2052			
	Sta	to	Aruna Nath 31. Date filed (Month, Da	av. Year)							ŏ, Ro	ckvi	LIE, MI) 2(0852			
.33	Registi		FEB	3 2 2 20	05	gers.	, 1	ture A	BALL B									

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2005 1771										0771.	
	Physici		1. Decedent's Name (First, Middle, Las Ruth	Birck	bich1						2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give Washington County	Hospital	Hospital			4b. City, Town, or Location of Death Hagerstown				4c. Count	4c. County of Death Washington	
	Funeral Director		5. Social Security Number 6. Sr 188-26-7606 1 Usual Residence of Decedent	9X 7. A □ M 2 🖾 F	ge (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	Min.	8. Date of Bird (Month, Da Dec 3	y, Year) 1, 1932	Cou	place (State or Foreign ntry) nnsylvania
21215-0036	e Maryland	ctor	10a. State 10b. County Maryland Montgo	mery	10c. Cit	y, Town or Lo	wood							10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with th	ai Director									10g. Citizen of USA	Citizen of What Country? USA		
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 te marked other then "natural", or Itams 23a or 28e-f show or other treumatic event, the Medical Evaniner must be notified at	l by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No		Was Decedif Yes, spec		panic Oric , Mexican S <i>pecify:</i>	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla Specia	ck, White,	can Indian, etc. nite
	od within 72 hogiene. er then "natu , the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	(Give life. I	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) retary					16b. Kind of Business/Industry restaurant				
Maryland	ould be filed Mental Hygid arkad other atic evant, I	To Be (17. Father's Name (First, Middle, Last) John Chupka								<i>(First, Middl</i> e, Ba rt ko	Maiden Sumai	me)	
Mary	12 should be h and Mental 7 le markad c rreumatic evi		19a. Informant's Name/Relationship (7									er, City or Town	·	· ·
Baltimore, I	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 le any injury or other tree once.		Lisa White - dau 20a. Method of Disposition 1 Surial 2 Cremation 3 Comparison 5 Other (Specify	Removal from State	, 0	Place of Dispo emetery, cren tler Co	sition (Nam natory or ot	e of her place)		Date	, Maryl 20c. Location Butler	- City or T	
Balti	permit. Departn Importe any inju		21. Signatur Tuneral Service Licen	Mas	race	\ /						NERAL H		21740
	Physician /Medical		23a. Part1. Enter the disease, or configurations, or heart failure. List only disease or condition resulting in death)	a	Stone	e Rev	er the mode ral E	of dying	such as	cardiac d	r respiratory ar Hemod	alysis		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Diak	Dialeta Mellitu								Chloric -	
8760,	cate ba exacuted oblysicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										Chy	
.O. Box 68	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pre Other (spe	egnancy ecify)					ate of delive	ery Day Year
rds, P	w requires that been signad b should be deta		Part II. Other significant conditions or	ontributing to death	but not res	ulting in the ur	nderlying ca	iuse givei	n in Part I.		1	obacco use con es 2 No		he cause of death?
al Records,		Completed									24a. Was autop perfor 1 \(\text{Yes} \)	med?	prior to co death?	opsy findings available impletion of cause of
f Vital	Physicien: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Thipati	ent 2 🗆	ER/Outpatien	it 3 DO/				n <i>(Check only o</i> me 5 ☐ Resid	ne) lence 6 □Otř	ner (Specil	(y)
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death 1			28b. Time of Injury	М	Rc. Injury Work?	at	No	28d. Describe h	low injury occur	red	
	tal or Att s after d el Direct ed in by	Certifi	4 Homicide determined	28e. Place of In	ace of Injury - At home, farm, street, factory, office zilding, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	ne Hospital or 124 hours afte ne Funerel Dir	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	vsicien: To the best liner: On the basis of and manners	of examina	wledge, death tion and/or inv	n occurred a vestigation,	t the time in my opi	, date and nion, deat	j place, a h occurre	and due to the ded at the time, d	cause(s) and made,	anner as s and due to	tated. o the cause(s)
)	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	НО			29c.	License	number	23		29d. Date signe	d (Month,	Day, Year)
51	4-2		30. Name and address of person who	mpleted cause of 340	death (Item	123a) (Туре.	Print)	Am	. 11	ld.	217	40		
Str.	Sta Registr		31. Date filed (Month-Pay, Year)	32. Regist	rar's Signa	ture	neste	,				, , , , , , , , , , , , , , , , , , , ,		

		-	State of Maryland / Depa	ortment of Health and Matificate of Death	ental Hygier	71115 07750				
	Physicia		1. Decedent's Name (First, Middle, Last) Lois Shirley Bergert		2. Date of Death Month Day Year February 15, 2005 3. Time of Death 7 September 15, 2005					
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 3536 Jamestown Road	4b. City, Town, or Location of Death Davidsonvil	1	4c. County of Death Anne Arundel				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 ▼ F 80 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. Aug. 16,	ar) 9. Birthplace (State or Foreign Country) 1924 Connecticut				
	the Maryland 28e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Anne Arundel	Davidsonville	7	10d. Inside City Limits 1 ☐ Yes 2 ☒ No				
	th with th	Dire	10e. Street and Number 3536 James town Road	10f. Zip Code 21035		Citizen of What Country?				
980	after dea or Items	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Sperifyes, specify Cuban, Mexican, Puerto F		14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036	c = 3	Completed by	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of workir DO NOT use retired)	ng 16b	. Kind of Business/Industry				
2 pr	init. Pages 1 and 2 should be filed within ariment of Health and Mental Hyglene. Critant: If Item 27 Is marked other then "njury or other traumetic event. It is marked.	Be Co	17. Father's Name (First, Middle, Last)	Artist 18. Mother's Name	(First, Middle, Maid	Teacher				
rylaı	hould b d Menta narked netic e	10	William J. Sheard	Martha Ar		T. C. T. C. I.				
Ma	alth and 2 st			g Address (Street and Number or Rura) 36 James town Road						
ore,	Pages 1 and of Hermant: If item		20a. Method of Disposition 20b. Place of Disposementery, crem			Location - City or Town, State				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other tra ence.		*4 □Donation 5 □Other (Spenify) Fort Line 21. Signature of Funeral Service Lylensee 22	. Name and Address of Facility Joh	nn M. Tay	entwood, Maryland lor Funeral Home, Inc. Annapolis, MD 21401				
	Centificate be executed from the principal of the pural-transit and the pural-transit are as the pural-transit and the pural-transit are as the pu	dicai Examiner	23a. Part1. Enter Me disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate devents resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):		r respiratory arrest,	Approximate Interval Between Onset and Death				
O. Box 6	death e atter	2	ıysician/Me	ysician/Me	nysician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
rds, P	w requires that the been signed by th should be detache		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?				
Vital Records,	The law ate has b page 2 sk	Completed			24a. Was an autopsy performed 1 Yes 2					
	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ 40 Hospital: 1 □ Inpatient 2 □ EH/Outoatien	26. Place of Death		6 □Other (Specify)				
Division of	To the Hospital or Attending Phys within 24 hours atter death. To the Funerel Director: After this completely filled in by the funeral di	Certification; T	27. Manner of Death 1	28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	28d. Desc <i>ri</i> be how in	njury occurred and Number or Rural Route Number,				
ā	ospital o hours aft inerel Di	ai Cer	29a. Certifier 1—Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place, a	and place, and due to the cause(s) and manner as stated.					
	the Hi thin 24 the Fi mplete	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or invand manner stated. 29b. Signature and title of certifier	29c. License number		and place, and due to the cause(s) Date signed (Month, Day, Year)				
	F 3 F 8		* Kyllin	D36761		2/16/05				
			30. Name and address of person who completed cause of death (Item 23a) (Type, 2448 Holly Ave Stello P		REIBMAD 214	n, np				
	Sta Registi		FEB 1 8 2005 32. Figistrar's Signature	and the						

		For State Registrar	State of Maryla		tificate of			N2005	07751	
Physic	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death	
/Medi Examir		Robert M. Bowi 4a. Facility Name (If not institution, give			4b. City. Town, o	r Location of Death	EBRUDA	4c. County of Deal		
Exami	iei	Peninsula Regiona	el Medical	Centr	SAL	136414		Wicom.		
Funeral Director		210-09-3040	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth 3. Mgnth 1991 Y	9. Birt Co	hplace (State or Foreignatry) Md .	
ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limit	
e-fsh	ctor	De. Sussex		Laurel					1 □ Yes Ž□ N	
with th	Director	10e. Street and Number			10f. Zip Code			Citizen of What Co	untry?	
ns 234	Funeral	7007 Sharptown Roa	1d. Was Decedent Ever in	U.S. 13. V	199.			USA 14. Race - Ame	rican Indian	
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Exactinate the inclined at once.	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	fYes, specify Cuba 1 ☐ Yes 2 <mark>X</mark> No	ispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	can, etc.)	Black, White, etc. Specify: White		
72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	tent's Usual Occup	durina most of working	161	o. Kind of Business/	Industry	
within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		neer	1)		U.S. Gove	rnment	
e filed other vent. I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Mai	den Sumame)		
Menta Menta arked atic e	ToE	John Bowie				Ethel Fr				
d 2 sh th and 17 is m traum		19a. Informant's Name/Relationship (T) Audrey Allen, Dat				and Number or Rural . urch Rd.		ity or Town, State, 2 y , Md . 21		
s 1 an f Heal item 2 other		20a. Method of Disposition	20b.	Place of Dispo		Da		. Location - City or		
Page nent o ant: if ury or		12 Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)			ows Cem.	2-25-0	5 La	urel, De.		
permit. Departr import any inju		21. Signature of Funeral Service Licens	99		Name and Address	ss of Facility eral Home				
Physician		23a. Part1. Inter the disease, or impl	ical ons that caused the de	ath Do not ent	OO W. St	. Laurel,	Pc. 1995	6	Approximate	
		Immediate Cause (Final	de couse on each line.			9, 00011 20 0210120 011	ospilatory arrest		Interval Between Onset and Death	
/Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):	7					
Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	S annual all						
ecuted and -fransit	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse							
	<u>@</u>	resulting in death) Last	Due to (or as a conse	equence of):						
cate be ohysici the bu	dicai		d			 				
Attending Physicien: The law requires that the death certificate be ex r death. r death. sector: After this certificete has been signed by the ettending physicien a sector. After this certificete has been signed by the funeral director, page 2 should be detached for use as the burial	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year	
res that the signed by be detaction	y Ph	Part II. Other significant conditions con	ntributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
w requires been sign should be		ACUTE REA	IAL FAI	LURE			1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Whiknow	
e law requ has been ge 2 shouk	Completed	ANEMIA						Ja. Was an autopsy performed? 24b. Were autopsy findings avail prior to completion of gause death?		
ysicien: The is certificete hadirector, page		ATHEROSCLEROT	ic CARDIUI	/ASCUL	AR DI	SEASE	performed 1 ☐ Yes 2 🖸	l? death? No 1 ☐ Yes	212 No	
sicien: Th certificete irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	□ ER/Outpatien	Othe	26. Place of Death		e 6 □Other (Spec		
ding Phys n. After this funeral di	n: To	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Work		d. Describe how		iny)	
ttendir death. stor: Af / the fur	Certification:	2 ☐ Accident investigation			M 1 🗆	Yes 2 □ No				
or At after d Direct in by	ertifi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Numb City or Town, State)								
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exemi	sician: To the best of my ki ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my of	ne, date and place, and pinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
를 돌 를 들	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	, Day, Year)	
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with the second	9	30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type, I	1.4217.17	OK SHI	NO STEAM	1	(30)	

1. December Name (First Indeed Last) Thomas W. Bird				State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. O O C								(a) and the total					
** Postly year of Charles School Security Function School Security Func	I			1. Decedent's Name (First, Middle, Last)							Mont	2. Date of Death Month			3. Time of Death		
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The control of the co		ath w	ral														
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Vijay Karumbunathan 201 Hall Highway. Crisfield MD 21817		e Hospita 124 hours Funerel letely filled		(Check only 2 Medical Examin	ner: On the basis	s of examina	owledge, death ation and/or inv	occurred	at the tim	e, date end p inion, death o	lace, and due to occurred at the t	the caus	se(s) and ma and place,	anner as state and due to the	ed. e cause(s)		
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State 31. Date filed (Month-Description) 32. Resister's Signature	_	. Da		Dr. Vijay Karumbu	nathan	201	Hall H	Iiqhw	ay, (risfie	eld. MD	2181	7				
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			1 - State of Man		artment of Health and tificate of Death		piene 005	07753
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day Year	3. Time of Death
	Physici: /Medic		Elizabeth Blocker			Februar		7:20a M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	ath	4c. County of Deat	h
			Bradford Oaks Nursing Hom		Clinton If Under 1 Year If Under 24 Hr		Prince (
	Funeral Director		1 🗆 M 2 📆 F	In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birtl (Year) Co	hplace (State or Foreign untry)
	D		578-36-7017 Usual Residence of Decedent	94		Jan.JI,	1911 Edge	efield,S.C.
	nylan show	_		Oc. City, Town or Lo				10d. Inside City Limits
	8a-f	Director	Maryland Prince Georges	Upper Ma				1 X Yes 2 □ No
	with th	늠	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	
	eath v	eral	11 Bannington Drive 11. Marital Status 12. Was Decedent Eve	or in II S 12 1	20774		United Stat	
· ^	r Item	Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	51 III 0.5.	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue	orto Rican, etc.)	Black, White	
99	be filed within 72 hours after death with the Maryland hal Hygiene. id other than "natural", or items 23a or 28a-f ahow event, the Madical Evarination must be notified at	b	3 ⅔ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🙀 No Specify:		Specify: Bla	ick
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation kind of work done during most of w	orking	16b. Kind of Business/	Industry
7	ithin nan "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired)	Diking		• •
7	iled w tygiei her ti	20	6th 17. Father's Name (First, Middle, Last)	Ho	ousewife	/Fina A 6 dalla	Domestic	
Maryland 21215-0036	d be fortal hed of	Be c			Marie	Monage	Maiden Sumame)	
2	shoute nd Me mark matic	2	Eddie Adams 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or F	Morgan	r City or Town State 7	in Code)
S	nd 2 state at trau		Twanda Johnson/ Granddaught		nnington Drive			20774
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Evantment be realified at ODGe.		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or	Town, State
Ē	Page nent c int: If iry or		1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify)	Ft. Line	1	1, 2005	Brentwood,	Md.
alt	rmit. spartn sporte y inju		21. Signature of Funeral Service Licentee	22				
<u></u>	82 5 8 8		Auth Clipang in DI		Name and Address of Facility Alexander S. Pope 538 Marlboro Pil			20747
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not enti	er the mode of dying, such as cardi	ac or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	is sclouding	heart or seem	<u> </u>		Onset and Death
п	/Medical Examiner		Due to (or as a c	onsequence of):				
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o,	exec en an rial-tr	Еха	resulting in death) Last C. Due to (or as a c	consequence of):				
8760,	death certificate be executed e attending physicien and of for use as the buriat-transit	dical	d					
9	ing ph e as t	Med	IF FEMALE:					
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live birth 2 [☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deli	very Day Year
o.	that the death certific ed by the attending F detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at tim 9 Unknown 9 Unknown	ne of death 5	Other (specify)			
<u>a</u>	that i		Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Vital Records,	The taw requires that the tee has been signed by the bage 2 should be detache	Completed				24a. Was a		topsy findings available
Ä	The tay te has bage 2	mo				autops perfor		completion of cause of
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of D	eath (Check only or	/	
	Physic this ce al dire	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatien		Home 5 Resid	ence 6 Other (Spec	cify)
ū	Attending Physicien: r death. ector; After this certific by the funeral director, i	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
isio	death.	icat	2 Accident investigation 3 Suicide 6 Could not be	Athone for the	M 1 Yes 2 No	29f Logation (C	to a d a d d d combar a d D	and Davids Manager
Division of	l or Attenuation after deati	Certification:	4 Homicide determined 200. Place of figure building, etc. (· - At home, farm, stre (Specify)	eet, ractory, office	City or Town	treet and Number or Ru n, State)	rai Houte Number,
_	Hospitel		29a. Certifier 1 Certifying Physician: To the best of r	my knowledge, death	occurred at the time, date and place	ce, and due to the c	ause(s) and manner as	stated.
	T 4 II 0	Medical	(Check only one) 2 Medical Exeminer: On the basis of example and manner states	xamination and/or inv	restigation, in my opinion, death occ	curred at the time, d	ate and place, and due	to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month	n, Day, Year)
_			- war y variety		1535206		February 22	2, 2005
R	(2)			1701 Living	Print)	wash inct	us, mny/	nL
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2:3 2005		W			

		1 - For State Registrar	State o	f Marylan	•	artment of I	Health and M Death		iene	005	07754
Physic	ian	1. Decedent's Name (First, Middle	, Last)					2. Date of Death Month		Year	3. Time of Death
/Med		Theresa	Mildred	Cannor	a			Month.	19 19	2005	1347 M
Exami	iner	4a. Facility Name (If not institution	1.1 .1	1 1.	41	4b. City, Town, o	or Location of Death		4c. Co	HICIMI	
		5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	If Under 4 Hrs.	8 Date of Birth			
Funera Director		214-52-1103	1 M 2 M F	57	Yrs.	Months Days		8. Date of Birth (Month, Day, Jan. 23,	Year)	Mary	place (State or Foreig intry)
		Usual Residence of Decedent						Jan. 2J	1740		
nylan how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural, or Itams 23e or 28e-f show ont, the Medical Examination untilled at	Director	Maryland Wicom	ico		Salisb	ury					1 TYYes 2 □ No
ith th	Dire	10e. Street and Number				10f. Zip Code		10	0g. Citizen	of What Cou	intry?
ath w	-E	1415 Delaware			0 10	2180		77 37		USA	in a la dia
ter dear	Funeral	11. Marital Status 1 □ Never Married 2 Marr	Armed Fo		.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	14.	Race - Ameri Black, White	
Inial ylailla A. I. I. J. CO. O. O. O. Should be filed within 72 hours aft lith and Mental Hygiene. 77 is marked other than "natural", or treumatic event, the Medical Exert.	by F	3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes If Yes, Gir Year or D	ve		1□Yes 20 No	Specify:		Sp	ecify:	a a la
72 hours "natural",		15. Deceden	t's Education		16a. Dece	dent's Usual Occu	pation	.	16b, Kind	of Business/Ir	ack
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d with	E O	10	Jane Gamaga (Neve	r Worke	d.			Never	Worked
	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle, N	Maiden Su	mame)	
should be ind Mental i marked o	10	Russell Whi	te				Dora	Peters			
2 sho and Is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stree	t and Number or Run	al Route Number,	City or To	own, State, Zi	p Code)
and palith n 27		Alton Cannon	Spouse_	1	317	Old Deni	ton Road,				
of He		20a. Method of Disposition	3 □Removal from	State 20b. F	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Locat	tion - City or T	own, State
Pag ment ent: ury c	1	'4 □Donation 5 □ Other (S		Ca		Cremator	And the second s	5-2005		r,Dela	ware
permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic.	1	21. Signature of Funeral Service	Licensee	1_	2	2. Name and Addr Bennie	Smith Fund	eral Home	e -1- M-	1 1	21672
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Physiciar Medica/		disease or condition resulting in death)				EMPAY	TEMM				
Examine			Due to	(or as a conseq	quence ot):						
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uted J nnsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S								
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that the death cerifica ed by the attending ph detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		□Ectopic pregnand	cv		230	1. Date of deliv	
dea he att	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of c		Other (specify)				Month	Day Year
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res tha igned be del	by	Part II. Other significent conditi	,	leath but not res	suiting in the i	anderlying cause g	iven in Part I.				the cause of death?
w require been si should I	ted	ALABT B	LOUN					1200			
law lasb	npie							24a. Was a autops	V	24b. Were aut prior to o death?	topsy findings availabl ompletion of cause of
The lav	ပ်							perform 1 Yes 2	2 DrNo		2 No
ician: The certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:				then	th (Check only on			
ding Physician: h. After this certific funeral director,	LO L	1 Yes 2 No	115		ER/Outpatie	ALL DOV		ome 5 Reside			nty)
Jing F	ion	27. Manner of Death		of Injury oth, Day Year)	Injury	W	ork? ☐ Yes 2 ☐ No	28d. Describe ho	ow injury o	ccurred	
ttendii death. ctor: A y the fu	icat	2 Accident investi	ant he	e of Injuny - At h	nome farm c			28f Location (St	reet and N	Vumber or Ru	ral Route Number,
after deat Director:	Certification:	4 Homicide determ	nined 200. Flac	ling, etc. (Speci	fy)	treet, factory, office	9	City or Town	n, State)	Vall201 01 1101	ar riodio reambor,
To the Hospitel or Attending Physician: The law requires that the death certifical within 24 hours after death. To the At hours after death. The Funest Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical C		Examiner: On the				time, date and place, opinion, death occur				
o the	Me	29b. Signature and title of certifie				29c. Licer	nse number	2	9d. Date s	signed (Month	, Day, Year)
F 3 F 0		DA M	malman			12	01/2		2/	19/03	<i>,</i> ,
		30. Name and ddress of person	who completed car	use of death (Ite	m 23a) (Tvne						
		DENINE O. Chad	Dick, MI	INA)	P. Con	RASII. CD	Salisbu	ince M.D	. 21	801	
	State	31. Date filed (Month, Day, Year	32.1	gistrar's Sign	ature	a .	. 3411304	7 110	- 21	001	
Regi		FEB 2	2005	Parace	13 h	Sail 1					
DHMH 17 Rev	1/2001				-	26.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiem reUU \supset Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FEBRUARY 19, 2005 GRACE MOORE CHANCE 9:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **CENTREVILLE** QUEEN ANNE'S CORSICA HILLS NURSING FACILITY If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year JAN. 6, 1917) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F MARYLAND 88 Director 22**0-**12-1312 Usual Residence of Decedent permit. Peges 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then "natural, or items 23s or 28e-f ehow empting or other treumatic event, the Medical Exeminar must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director SUSSEX SEAFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19973 USA 518 SUSSEX AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify ģ 3X Widowed 4 ☐ Divorced WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE HEALTHCARE 12 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT A. MOORE MARY E. FRENCH 2 19a. Informant's Name/Relationship (Type, Print)GRAND-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLE ANNE KAUFHOLD/DAUGHTER 2195 OLD PHILADELPHIA PIKE, LANCASTER, PA 17602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY 2-23-2005 CENTREVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complication. Unit caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatic Counnoma Tigear /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No To the Hospitel or Attending Physician: teral Director; After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 45 hursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier t 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOO 61688 02/21/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD-21619 Dr. RUPAL R. DESAI Di Donato Douve cheter 2108 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

21		1	State of Maryl 1 - State Registrar AMEND TTEM #8 10d 1281	and / Depa		alth and Me	ental Hygiei Reg.	711115	07756
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) L. Barry COSTI			F	2. Date of Death Month 'ebruary	19, 2005	3. Time of Death 5:10 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) Montgomery Hospice Casey Hous	e.	4b. City, Town, or Le			4c. County of Death Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	rs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth (Month My, Ye	9. Birth	place (State or Foreign
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	Marylan f ehow	ō	10a. State 10b. County 10c Maryland Montgomery 10c	City, Town or Le	ocation ma Park				10d. Inside City Limits 1
	r 28a-	Director	10e. Street and Number	1410	10f. Zip Code		10g.	Citizen of What Cou	7111
	ath witt	ral D	8005 Sligo Creek Parkway		209			nited Sta	tes
320	urs after dea ai', or items	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Amed Forces? 1 ☒ Yes 2 □ No 1 If Yes, Give Year or Dates:	60 s 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Spec Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentalle Hygiene. Inportment of Health and Mentalle Hygiene. Inportment: If Item 27 is marked other then "naturel; or Items 23e or 28e-f ehow any injury openher treumatic event, the Medical Examinar must be right of an once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupati a kind of work done du DO NOT use retired)		7	. Kind of Business/Ir	·
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Z	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (Type, Print) Albert Costilo, Son		ing Address <i>(Str</i> eet a <i>n</i> 2 Pinehave				20852
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Saltin	ermit. P Separtme Inporten Iny Injury		21. Signature of Figure ansatz vice processes		2. Name and Address orchinsky				
	707 # O		23a Part I. Enter the disease, or complications that caused the) 2 death. Do not en	54 Carroll	St., NW,	Washing respiratory arrest.		20012 Approximate
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Myelodyst Due to (or as a condition and the condition are condition)	lastic					Interval Between Onset and Death MONT INS
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Vital Records,		Completed					24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:			26. Place of Death			500
Ö	Attending Physician: r death. sctor: After this certific by the funeral director.	ation: To	1 Yes 2 No 10 No 11 Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	2 ER/Outpatie 28b. Time Injury	of 28c. Injury a Work?	at 28	e 5 ∐ Residence 3d. Describe how i	e 6 X Other (Speci injury occurred	House
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	To the Hospitei or Attendin within 24 hours after death. To the Funeral Director; Are completely filled in by the funeral process.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 1 Description of the desired form of the desi	knowledge, dea mination and/or in	th occurred at the time nvestigation, in my opin	e, date and place, ar nion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Month,	, Day, Year)
1	10+1		I Chihi fyme		BR 42	16114	Fe	bruary 19	, 2005
			30. Name and address of person who dompleted cause of death Chitra Rajagepal, M.D., 6001	Muncast	er Mill Ro	ad, Rocky	ville, MI	20855	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature A	arte				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Edward D. Colleran February 16, 2005 9:05 /Medical am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Garden at Riderwood Village Silver Spring Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1⊠M 2□ F Yrs 220-40-4022 90 Director Nov. 26, South Dakota Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryle Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "neturel; or items 23a or 28a-1 ahon any injury or other traumatic event, it a Medical Examinat must be notified at 1 ☐ Yes 2 TNo Prince George's Directo Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road, Apt. 1123 20904 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Tx Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Personnel Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward W. Colleran 2 Cora McGilvra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Lund/Daughter 6834 Sewells Orchard Drive, Columbia, MD 21045 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Feb. 19, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2005 Silver Spring, Maryland 21. Signature of Funeral Service Licensee _22 Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 il 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pneumonia Examine Due to (or as a consequence of) Examiner Failure to Thrive the attending physician and hed for use as the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of): Coronary Artery Disease Box 68760 Physiclan/Medical Due to (or as a consequence of) resulting in death) Last The law requires that the deeth Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4X Unknown þ page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen After this certificate has 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No l or Attending Physician: efter deeth. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4₺ Nursing Home 5 □ Residence 6 □ Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) edical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending efter deeth.

Director; Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Hospital 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dullen rumaua,MD D59524 February 17, 2005 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen puthumana M.D. 3110 Gracefield Road, Silver Spring, MD 20904

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

FEB

22

32 Registrar's Signature

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Examir		4a. Facility Name (If not institution, give Shady Grove Adven				Town, or	Location of 0		obi dai	4c. Co	unty of Death		A
Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs	. last birthday) 7 Yrs.		1 Year Days	If Under 24	Min.	Date of Birti (Month, Day 08/25/	h y, Year)	9. Birth	place (State ontry) ombia	or Foreign
a-f show	ctor	10a. State 10b. County MD Montgome:		ity, Town or Lo								10d. Inside C 1 🏋 Yes	ity Limits
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permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "neturel", or Items 23e or 28e-f show apprient; if Item 27 is marked other than "neturel", or Items 23e or 28e-f show apply four or positive treumatic event, tre Madical Examinar manalize notified at once.	d by Funeral	8971 Centerway Ro	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Dece	dent of Hi city Cuba	spanic Origin n, Mexican, F Specify: C	Puerto Ric	fy Yes or No- can, etc.)	14.	Race - Ameri Black, White		
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Heelth and the tem 27 is in other treum		19a. Informant's Name/Relationship (T) Nelly Stella Mood 20a. Method of Disposition	y, Daughter	8971	Cente	erway	Road	, Gai	ithersl	burg,	MD 208	379	
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To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	tlon; To Be	27. Manner of Death 1 X Natural 5 ☐ Pending	Hospital: 1気Inpatient 2日 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injury Work	or: 4 ☐ Nursi	ng Home 28d	Check only or 5 Resid d. Describe h	ence 6 🗆	Other (Specificurred	'y)	
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2		30. Name and odress of erson od			Print) RO	bert	D. K		aldy, N		7 2003		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Tem T per phys 2541 3-17-05 vt
State of Maryland 7 Department of Health and Mental Hygiene 2 0 0 5 07759 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2005 Mary A. Coates Feb. **Physician** - Mary S. Coates 18, 9:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince George Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
June 23, 1930

9. Birthplace (State or rower)
Country)
Washington, DC. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🖾 F 74 213-44-6611 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State r then "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at Maryland Prince George Capitol Heights Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4911 Emo Street 20743 United States Funeral lifed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2X No Specify: ۵ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5th Homemaker Domestic permit. Pages 1 and 2 should be liled v
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eny injury or other traumatic event, this
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Ford James Thomas Sovov 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Colbert/Daughter 4911 Emo St.; Capitol Heights, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park Feb. 26, 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD. 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 21. Signature of Foneral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Kidney Due to (or as a consequence of): **Physician** Discinn /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offe Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of): ng physician a a as the burial-Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐No 3 ☐ Probably 4 ☐Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 □ npatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 1 Matural 5 Pending investigation death. 1 Yes 2 No 2 Accident in by the Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after Hospital or 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

CR (3)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

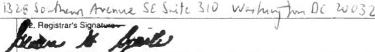
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of Vital

Division

State Registrar 3/2 DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) FEB 2-3 2005

Rich ARD Palmer MD



MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20055120

February 18 Was

State of Maryland / Department of Health and Mental Hygiene | For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Ruth Ε. Crowl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 3-24-17 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Yrs. 186-18-8942 87 Oxford, Director Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shov other treumatic event, the Madical Examinar must be notified at Y□Yes 2□No MD Baltimore Cockeysville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after deeth with 1034 Saxon Hill Dr. 21030 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) X-ray Technician Healthcare 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Heelth and Mental Pant: If Item 27 Is marked of Samuel H. Crowl Ellen Jenkins ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Barrick Nephew 1034 Saxon Hill Dr. Cockeysville, MD 21030 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ŏ cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or 9069. ^¹ 4 □ Donation 5 □ Other (Specify) Evans Crematory 2-21-2005 Leola, PA 17540 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Edward L. Collins Funeral Home, Inc. 86 Pine St. Oxford, PA 19363 r the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first any leading to immediate the first any leading that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. DISSEMINATED INTRAVASCULAR COAGULATION Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? METABOLIC ACIDOSIS 24a. Was an autopsy performed? Yes 24 No 2X No 1 Yes 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🔀 No After th 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deatl Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide 24 hours a 29a. Certifier 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

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			Decedent's Name (First, Middle, Last)				. Date of Death	3. Time of Death
	Physicia		ROBERT JOHN DOYLE	*			Month February	18, 2005 1500 p M
	/Medić Examin		ta. Facility Name (If not institution, give s		4b. City, Town, or Loca	ation of Death		4c. County of Death
			2210 PINEY CREEK I	ROAD, APT 2	CHESTER			Queen Annes
	Funeral Director		5. Social Security Number 6. Sex 1 🕱	M 2□F 7. Age (In yrs. last birthda 59 Yrs.	Months Davs Ho	Under 24 Hrs. 8 ours Min.	Date of Birth (Month, Day, Ye. UG. 21,	ar) 9. Birthplace (State or Foreign Country) OH
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	79 N	Director	MD QUEEN AND 10e. Street and Number	NE'S CHESTER	10f. Zip Code		100	Citizen of What Country?
	Will will	۵		DOAD ADT 2	21619		US	·
	ns 23	Funeral	2210 PINEY CREEK I		3. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Speci		14. Race - American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Heelih and Mental Hygiene. If of Heelih and Mental Hygiene. or other traumatic event, tra Medical Examblar intuation notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Micropole	Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		lexican, Puerto Rii pecify:	can, etc.)	Black, White, etc. Specify: WHITE
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lar	uid be Aenta rrked rice	10 E	JOHN DOYLE		Н	ELEN SZE	NBORN	
Maryland	2 sho and f is me		19a. Informant's Name/Relationship (Type					ty or Town, State, Zip Code)
≥.	and and seelth m 27 m	3-	PAULA J. DOYLE/EX-		25 ENGLISH OA			
Ore	ges 1 t of H if Itel		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Re	emoval from State cemetery, o	sposition (Name of crematory or other place)	Dat		. Location - City or Town, State
Baltimore,	tmer tent tent		'4 □ Donation 5 □ Other (Specify)		XE CREMATORY 22. Name and Address of		2005 ST	EVENSVILLE, MD
Bal	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Lice of		FELLOWS, HEL 106 SHAMROCK	FENBEIN	& NEWNAM HESTER,	FUNERAL HOME, P.A. MD 21619
			23a. Part 1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death. Do not e cause on each line.	enter the mode of dying, su	uch as cardiac or	respiratory arrest,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	LABITITIE	<u>.</u>	Sequentially list conditions, b	. Due to for as a consequence of .				
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Ä	The late has page	E O					performed	? death?
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ū	ith. :: After this tuneral	ino	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?		ld. Describe how i	njury occurred
Sic		icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm		2 No	If. Location (Stree	t and Number or Rural Route Number,
Division	spitel or Attencours after death terel Director: filled in by the	Certification:	4 Homicide determined	building, etc. (Specify)	, street, factory, office		City or Town, S	
	pite ours ore ere	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sicien: To the best of my knowledge, d ner: On the basis of examination and/o and manner stated.	eath occurred at the time, or investigation, in my opinion	date and place, an on, death occurred	d due to the caus d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	othe Hos within 24 ho To the Fun completely 1	Med	29b. Signature and title of certifier	~	29c. License nu	ımber	29d.	Date signed (Month, Day, Year)
1	7 × 5		· Carol H	Ploon ind	OCME		Fe	ebruary 19, 2005
(10	ms)		30. Name and address of person who co	empleted cause of death (Item 23a) (Ty	pe, Print)			
_			CAROL HALLA	wind	111 Pe:	nn Stree	t Balti	more, Maryland 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 2 2	32. Registrar's Signature	South			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** LILLIAN NAOMI DORRELL FEB. 21 2005 10:20 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Oeeth 4b. City, Town, or Location of Death Examiner CENTREVILLE QUEEN ANNE'S CORSICA HILLS NURSING CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 215-07-3971 84 SEPT.9,1920 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, Ite Medical Examinat Faust to natified at 1X Yes 2 □ No Director QUEEN ANNE CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 WHARF LANE 21617 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GARMENT MANUFACTURING -0-SEAMSTRESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHANEY CLOUGH ELLA V. BOWERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AREY E. GUNTHER/ DAUGHTER P.O. BOX 395, CENTREVILLE, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of h Important: It ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CHESTERFIELD CEMETERY 2-25-2005 CENTREVILLE, MD 21. Signature of Funeral Service 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULLUNAM /Medical Due to (or as a consequence of) Examiner Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence or). Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): burial attending physician P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hnowz 1 Tes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Oescribe how injury occurred After 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 23889 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) Street, Cifestertown, Wed 21620 John C. ARRABAL 223/15/64 TR. HD. 31. Date filed (Month, Day, Year) FEB 2 3 32. egistrar's Signature State 2005 Registrar

			1 - For State Registrar	State of Mar	yland / De		nt of H	ealth and	•	ygiene 0 0	5 07763
			Decedent's Name (First, Middle, La	ist)					2. Date of D	eath	3. Time of Death
	Physicia /Medic		Elmer Walter Der						Febru	ary 25,	2005 0230M
	Examin	er	4a. Facility Name (If not institution, gire Mallard Bay	re street and number) Convalesc	rent	_		Location of De		4c. County of	Death RSE
Н	Funeral				In yrs. last birtho	(ay) If Und	ler 1 Year	If Under 24 h	rs. 8. Date of B		9. Birthplace (State or Foreign Country)
	Director		220-10-9343	1∰M 2□F	79 Yrs	Month:	s Days	Hours M	lin. (Month, 2 12/1	0/25	Maryland
7	D. A		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	r Location					10d. Inside City Limits
1	f sho	to		nester	-	desda	ale				1 ☐ Yes 2X No
4	or 28a	irec	10e. Street and Number			10f. Z	Zip Code			10g. Citizen of Wh	nat Country?
4	23a c	Funeral Director	4760 Maiden For	est Road				21659		United	States
7	Items Items	une	11. Marital Status	12. Was Decedent Event Armed Forces? 1X□XYes 2□No	er in U.S.	13. Was Dec If Yes, sp	edent of Hi becify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo- 14. Race Black,	- American Indian, White, etc.
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a	fental fental rked c	o B	John Dennis					Maggi	e Smith		
Mary	ond 2 state at the		19a. Informant's Name/Relationship Geraldine Deni		19b. N	lailing Addre	ss (Street a	and Number or n Fore	Rural Route Nurm	ber, City or Town, S Rhodes	tate, Zip Code) 21659 lale, MD
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Daltimo	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice Mutual 7. Ga	nsee hew		22. Name : 216	and Addres	ss of Facility F Main S	ramptom t., Fed	Funeral eralsbu	Home, P.A.
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1	ate be executed hysician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	· demy	elina	ting	nei	voloc	ic di	sease	lyear
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0	grPny erthis erald	 	27. Manny of Death	28a. Date of Injury (Month, Day)		ne of	28c. Injury Work			sidence 6 Other how injury occurred	
0	ath. r: Aft re fun	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	on	(e <i>ar)</i> Inju	M		Yes 2□No			
DIVISION	al or Atters after de Il Directo	Certification;	3 Suicide 6 Could not learnined		r - At home, farm (Specify)	, street, facto	ory, office			(Street and Number own, State)	or Rural Route Number,
	To the Hospital of Attending Prystician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of a miner: On the basis of ea and manner state	xamination and/o	leath occurre or investigation	ed at the timon, in my of	ne, date and pla pinion, death o	ace, and due to the	e cause(s) and mann e, date and place, an	ner as stated. d due to the cause(s)
,	withir To th	Me	29b. Signature and title of certifier				9c. License			29d. Date signed (
			Ppanso	~			Ho	0599	73	2/28/	05
			30. Name in address of person who	hnen	th (Item 23a) (Ty	pe, Print)	7 P	en hid	no mn	2/28/	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's		ou y	1_0	- WEICH	70 000	01013	
	Registr		MAR - 4 201	15 /	M.	En. M.					

		for State Registrar	Sta	te of M	larylan	d / Depa <i>Cei</i>	artmen rtificat				ental Hy	/giene Reg. No.	20	05	07761
		Decedent's Name (First, Middle,	Last)				Di l				2. Date of D	eath Day 24		2 [°] 0°5	3. Time of Death
Physi /Med		Patricia Ann D	ownes								Feb.				7:05P M
Exam		4a. Facility Name (If not institution,			-)				Location	of Death				of Death	•
		313 Mason Branc					•	een .	Anne If Under	24 Hrs	8. Date of B				lace (State or Foreign
Funera Directo		216-48-5886	6. Sex 1 ☐ M 2	T E	ige (In yrs. 57	last birthday) Yrs.	Months	Days	Hours	Min	12/08/	lav. Year)		Mary1	try)
P.		Usual Residence of Decedent 10a. State 10b. County			10c. Cit	y, Town or Lo	ocation							10	0d. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow rmast be notified at	a	1													1 ☐ Yes 2X No
Ba-f	Director	MD Queen A	nne		Qu	<u>een An</u>	ne 10f. Zig	Code				10g. Citiz	en of V	What Coun	itry?
with the	D		h Doo					657				17	SA		
sath is 23	Funeral	313 Mason Branc			nt Ever in U	.S. 13.			spanic Or	igin? (Spe	ecify Yes or N Rican, etc.)		4. Rac	e - Americ	
in the lie	Š	1 Never Married 2 Marri	Arr	ned Force: Yes 2) [3?	ĺ					Rican, etc.)			ck, White,	
urs af	ρ	3√ Widowed 4 Divorced	l If \	es, Give ar or Dates			1 🗆 Yes	XL No	Specify	:			Specify	v: WI	nite
O Z I Z I D-UUSO filed within 72 hours after Hygiene. other then "nature", or fte ent, ire Medical Exacting	Completed	15. Decedent (Specify only highes	s Education	nleted)		16a. Dece	dent's Usu kind of wo DO NOT u	al Occupa	ation during mos	st of work	ing	16b. Kir	nd of B	usiness/Ind	dustry
Frin 7	npfe	Elementary/Secondary (0-12)		llege (1-40	r 5+)							_	_		
N Bd wi	S		0	2		Par	alega	1 Se			e (First, Midd			irm_	
Maryland 21213-UU30 d 2 should be filed within 72 hours aff th and Mental Hygiene. 27 is marked other then "naturel", or treumatic event, tre Medical Exer-	0	17. Father's Name (First, Middle, I									: Newel				
Baltimore, Maryland 21213-U030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or items 23e or 28a-f ehow eny injury or other treumatic event, it a Medical Exactions man be notified as	은	Charles E. Ris		intl		10h Maili	ing Address	: (Street :			al Route Num				Code)
Mar 12 sh h and 7 is n		Peter Risley	пр (<i>туре, гт</i>	uncj							onvil:				
C, I and I and Health		20a. Method of Disposition			20b. I	Place of Disp cemetery, cre			-	-	Date			City or To	own, State
Pages nent of the		1 Burial 2 □ Cremation		al from Sta	(0	cemetery, cre ensbor			,	3/2/2	005	Gre	ens	boro	, MD
Baltimore, permit. Pages 1 ar Department of Hea important: If item: eny injury or othe		° 4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service			GIC										n Funeral
Department of the position of	ouc	1 Fr	1	le.	~						Greens				
3760, ate be executed This is a second of the second of th	al er ভ		a	Due to (or	as a consectas as a consectas as a consectas as a consectas as a consectas as a consectas as a consectas as a consectas as a consectas as a consectas as a consectas as a consectas as a consectat as a consectat as a consec	quence of):			_			dilesi,			Approximate Interval Batween Onset and Death
OX 68 certifica anding pl use as t	n/Med		1 4	□Live birth □Pregnan	me of pregr 1 2 □ Fet t at time of	al death 3	□Ectopic p		/		===	- :		ate of delive	ery Day Year
P.O. By that the death ed by the atte detached for	hys	9 Unknown		Unknow			V-2-2				60. 5	id taber			he cause of death?
(n s 50	2		ons contribu	ting to deat	h but not re	sulting in the	underlying	cause giv	ren in Par	11.		Yes 2		3 ☐ Prol	he cause of death? bably 4 □Unknown
cords w require been signated	lete	Rend Fail	me								24a. W	as an	24b.	Were auto	opsy findings available empletion of cause of
I Rec	duc											rformed?		death?	2□ No
	O	25. Was case referred to medica							26. Pla	ce of Dea	th Check on				
T N Silver	, 2	1 Yes 2 No	Hospit 28	al: 1 □ Inp ia. Date of (Month,		ER/Outpati	of	28c. Inju Wo		Nursing H	ome 5 AR				<i>fy</i>)
ion ndin ath. r: Aft	atio	1 ☑ Natural 5 ☐ Pendi 2 ☐ Accident invest	gation				М		Yes 2[□No					
Division i or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		e. Place of building	Injury - At , etc. (Spec	home, farm, s	street, facto	ery, office				n (Street an Town, State		iber or Run	al Route Number,
Division o To the Hospital or Attending Pt within 24 hours after death. To the Funerel Director: After it	Medical C		Examiner:	n: To the b On the bas and manne	is of examir	nowledge, deanation and/or	ath occurre investigation	d at the ti	me, date opinion, d	and place eath occu	, and due to t rred at the tin	the cause(s ne, date and	and m	anner as s , and due t	stated. to the cause(s)
o the	Me Me	29b. Signature and title of certific	er .				2		se numbe	- /	-	29d. Da	te sign	ed (Month,	, Day, Year)
H 5 H 3	,	1 1/2 1/2	were	Cm				17		036		2	1/2.	1/2	007
		30. Name and address of person	who comple		of death (It			rwe	Ch	o i fe-	MD	2,	16	19	
1111	State	24 Date filed (Month Day Year		-	istrar's Sig	nature	19	e./*							
Reg	gistrar		3 2005	>		. `	Low	0 3							

ORIGINAL

			1 - For 3-3-05 State Registrar Amend 20b. Per 1	State of Marylar		artment of F			giene Reg. No.	07766
in.	Physici /Medic		1. Decedent's Name (First, Middle, Last) JOHNL. POWA					2. Date of De Month	ry 19, 2005	1.23 A M
	Examin Funeral	er	4a. Facility Name (If not institution, give s Mary and Ten 5. Social Security Number 6. Sex	eral Hospi	last birthday)	BOLLING BOLLING If Under 1 Year	OVE (Irs. 8. Date of Bir	4c. County of De	ath irthplace (State or Foreign Country)
	Director		578-86-4737 Usual Residence of Decedent 10a. State 10b. County	M 2□F 79	Yrs.	Months Days	Hours M	in. (Month, Da Mar. 14		e, S. C.
	ne Maryla 8e-f shov biffied at	Director	D.C.		ashingt					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with ti		10e. Street and Number 5517 C Street.	C C		10f. Zip Code	20010		10g. Citizen of What C	
	eath rs 23	eral		2. Was Decedent Ever in U	IS 13 V		20019	(Specify Ves or No	U. S. A 14. Race - Am	
980	n 72 hours atler death with the Marylan Tratural', or items 23a or 28e-1 show Idisal Examinar musi be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba		(Specify Yes or No erto Rican, etc.)	Black, Wh	ite, etc.
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28e-1 show other treumetic event, the Madical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done o OO NOT use retired	during most of w		16b. Kind of Busines	s/Industry
2	led w tygier her th		12th	- Tr	Profes	sional p			Music	
and	d be fi	o Be	17. Father's Name (First, Middle, Last) Sam Donaldson					,	, Maiden Sumame)	
N.	shoulk nd Me mark merk	Ţ	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Street		l Busky Rural Route Numbe	er, City or Town, State,	Zip Code)
Ž,	and 2 alth a 27 is		Rachel L. Berry/S	ister				shington,		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre ance.		20a. Method of Disposition 1/2 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	cemetery, cren	sition (Name of natory or other place	·	Date 3-05 3/29/05	20c. Location - City o	
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service License	V. Gray	22	Name and Address H. S. Wash 4925 Bur	s of Facility ington of coughs f	l Sons Co Ave. N.E.	., Inc. .Washinato	r, D. C. 20019
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complik shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	pations that caused the deal e cause on each line. PNEM M Due to (or as a consect DEMYO	UNIA-	er the mode of dyin	g, such as card	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	death certificate be executed es attending physician and ad for use as the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a	wence of):	_				
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of conditions	ıl déath 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
<u>α</u>	se us	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.		obacco use contribute I	o the cause of death?
Records,	e law has b	Completed								utopsy findings available completion of cause of
Vital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		20,10
of V	80 80 75	2	1 ☐ Yes 2 ☑ No	· · · · · · · · · · · · · · · · · · ·	ER/Outpatient		4 Nuising		dence 6 □Other (Spe	ecify)
Division (ing After une	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		rat ⟨? Yes 2 □ No		now injury occurred	
Divi	or fte		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif				City or Tox		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one) 2 Medical Examin	cien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my or	oinion, death oc	curred at the time,	date and place, and du	e to the cause(s)
)	5 Wild		29b. Signature and title of certifier	e Da Mo		29c. License	29	527	February	19, 2005
2			30. Name and address offperson who con	(D, C/OINC	Trylar	a Ger	neral	Hospit	al	,
	Sta Registr		S1. Date filed (Month, Day, Year) FEB 2 3 2005	2. Régistrar's Signa	dive-	W		. /		

State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and M Certificate of Death		iene g. No.	05 07767
	G !	Decedent's Name (First, Middle, Last)	2. Date of Death	h _	3. Time of Death
1	Physician /Medical	DOROTHEA M. ENGLISH	FEB. 16,	, 2005	1:50 PM
	Examiner	4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Loc	cation of Death	4c. County of	Death
		HOLY CROSS REHAB AND NURSING CENTER SILVER SPE	RING	MONTGON	TERY
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	182-07-5072 86 Tis.	NOV. 09,	, 1918 P	ENNSYLVANIA
	pue &	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many 1 sho	MARYLAND MONTGOMERY SILVER SPRING			1X Yes 2 □ No
	or 28a-f s	10e. Street and Number 10f. Zip Code	10	g. Citizen of Wh	est Country?
	ath with the Maryler 23a or 28a-f show unit be notified at rai Director			- // / / /	at Godinay:
	r tems 23 ther must	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	SA 14. Race -	- American Indian,
21215-0020	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto F 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto F 1 Yes Give Year or Dates:	Rican, etc.)	Black,	White, etc. WHITE
5-0	ed within 72 ho ygiene. er than "natura it, the Medical i	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	1	6b. Kind of Busin	ness/Industry
21	within ene.	Elementary/Secondary (0-12) College (1-4or 5+)	,9		
7	Hygien ther then the the the the the the the the the the	12 HOMEMAKER		OWN HO	ME
n	d oth	17. Father's Name (First, Middle, Last) 18. Mother's Name		faiden Surname)	
Z	should Ind Men marke imaric	FRANCIS JACKEL EDNA HE	INE		
Maryland	and is m	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural			
	and dealth m 27	DR. JOSEPH M. ENGLISH III - SON 2008 REBECCA CT. SILVE			
5	Pages I nant of H ant: If ite	20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) IM Burial 2 □ Cremation 3 □ Removal from State	B. 21	Oc. Location - Cit	ty or Town, State
Ë	tmant tant: tant:	4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 20	005 S		PRING, MD
Baltimore,	permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: if Item 27 is marked othe any injury or other traumatic event, DRG. To Be C	21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINE 11800 NEW HAMPSHIRE	S-RINAL	DI FUNER	RAL HOME, INC.
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	-		Approximate
1	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) PNEUMONIA			Interval Between Onset and Death
	<u> </u>	Due to (or as a consequence of): ALZHEIMERS DISEASE			
	axecuted in end ial-transit	b			
oʻ		Sequentially list conditions, if any, leading to immediate gause. Enter Underlying			1
68760,	physicials the burner offical	that initiated events			
	ng ph as th	resulting in death) Last			
Вох	death cart le attendin le attendin le for usa sician/M	d			
<u>.</u>	deat be att	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tob	acco uee contri	bute to the cause of death?
P.O.	nat the death carting by the attending detached for use a Physician/M				☐ Probably 4 K Unknown
Ś	as the igned be de				
Division of Vital Record	requir		24a. Was an performe		24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	The ata hapaga		1 ☐ Yes	2 X No	1 ☐ Yes 2 ☐ No
ita i	Attending Physician: r deeth. sctor: After this certifica by the funeral director, I fication: To Be C	25. Was case referred to medical examiner? 26. Plece of Death			
<u> </u>	hysic his ce at dire	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Hom	e 5 🗆 Residen	ce 6 Other ('Specify)
2	ng PI fler th unera		3d. Describe how		
0	ttendii deeth. ctor: A y the fu	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Ξ	tal or Attending P rs after deeth. al Director: After t led in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	If. Location (Stre City or Town,		or Rural Route Number,
	illed i				
	To the Hospital or Attending Physician: The lew within 24 hours after deeth. To the Funeral Director: After this certificata has completely filled in by the funeral director, paga 2 Medical Certification: To Be Comp	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the date of my knowledge, death occurred at the time, date and place, and the date of my knowledge, death occurred at the time, date and place, and the date of my knowledge, death occurred at the time, date and place, and the date of the date o	d due to the cau	ise(s) and manne e and place, and	er as stated.
	To the Ho within 24 Pro the Fur completaly	one) and manner stated. 29b. Signature and title of certifier 29c. License number			
	F. 8 A E. A			BRUARY 1	Month, Dey, Year)
	(0	mesocial forcer warre, mis	r E.	DVAWI I	.09 2003
	(0	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARIA GOLDMARK, MD 15020 SHADY GROVE RD. # 300 ROCKVILL	E, MD 20	0850	
	State Registrar	31. Date filed (Month, Day, Year) FEB 2 2 2005 32. Registrar's Signature			

DHMH 16 Rev 6/95

			artment of Health and Mental H rtificate of Death	ygiene 0 0 5 0 7 7 6 8
		Decedent's Name (First, Middle, Last)	2. Date of I	Death 3. Time of Death
Phys	iciar dica		Month Februa	ary 13, 2005 9:25 A ^M
Exar			4b. City, Town, or Location of Death	4c. County of Death
		8100 Connecticut Avenue, Apt #807	Chevy Chase	Montgomery
Funer	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of E	Birth 9. Birthplace (State or Foreign Country)
Direct	or	055.05.3797 1⊠M 2□F 83 Yrs.	Feb. 1	0, 1922 New York, N.Y.
pu &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation	404 to 124 02 11 2
eho				10d. Inside City Limits 1 ⊠ Yes 2 □ No
the A	100	Maryland Montgomery Chevy C		
with a or	Ì	8100 Connecticut Avenue, Apt #807	10f. Zip Code 20815	10g. Citizen of What Country? U.S.A.
In yidilid X 1 Z 1 Z 1 Z 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Cinoral Directo	11. Marital Status 12. Was Decedent Ever in U.S. 13.		
Iter d	1	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Named Forces? 2 No 09/1942	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
urs a	1	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 01 / 1946	1 ☐ Yes 2 🛣 No Specify:	Specify: White
2 ho	potologic	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
thin 7	1 2	(Specify only highest grade completed) (Give life. College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	
A will will will will will will will wil	5	12th Sai	les Manager	Corrugated Boxes
as Hyen	a	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	le, Maiden Sumame)
Meni Meni arke	F		Eva Klein	
2 sh and ie m			ng Address (Street and Number or Rural Route Num	
and and lealth m 27		The second secon	Connecticut Avenue, #80	
Pages 1 nent of H nut: if Iter	10		sition (Name of Date matory or other place)	20c. Location - City or Town, State
mrit. Pages p-rtment of portent: if if	V		coln Crematory 02/19/05	Brentwood, Maryland
portrill. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Merida Hygiene. Importent: If the 27 is marked other than "natural; or items 23s or 28s-1 show any injury or other traumatics event, the Marinal Examination was the coulded at	Suce	21. Signature of Funeral Service Licensee	2. Name and Address of Facility INES-RINALDI FUNERAL HOM	E. INC.
		23a. Part1. Enter the dilease, or complications that caused the death. Do not ent	1800 New Hampshire Ave,	
		shock, or hear fure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
Physicia /Medic	_	disease or condition resulting in death)	t failure	Ce montho
Examine		Due to (* as a consequence of):	a. di cane	20
		Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):	an an towe	ageaca
uted d ansit	Evamin	cause. Enter Underlying Cause (Disease or injury that initiated events	•	, and a second
exec exec an an rial-tr	T Z	resulting in death) Last Due to (or as a consequence of):		
w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	100	d		
ntifica ng ph as th				
th cer tendir r use	1/46	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy	23d. Date of delivery
e dea he et	2	in the past 12 months? 1 Yes 2 No 9 Unknown	Other (specify)	Month Day Year
at the	Physician/M	9 Unknown		
res th	2	A sub-c-L-A - La - c-L-A - La -		tobacco use contribute to the cause of death?
requir een si	Completed	diahetos mellitus	1	Yes 217No 3 Probably 4 Unknown
a law a law a law a 2 s	100	hypothyroidism	24a. Wa	opsy prior to completion of cause of
The cate	2		per 1 \(\sum \text{Yes}\)	formed? death? 2 No 1 ☐ Yes 2 ☐ No
ician ician sertifi ector	a	examiner?	26. Place of Death (Check only	
Phys this	ļ.	1 Inpatient 2 EH/Outpatien		
ding Physician: The lav h. After this certificate hes funeral director, page 2.	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	how injury occurred
or Attan after death Director: in by the	i c	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, str.		(Street and Number or Rural Route Number,
after Dire	Certification.	4 Homicide determined building, etc. (Specify)	City or To	own, State)
To the Hospital or Attanding Physician: The law requires that the death cariff within 24 hours after death. To the Funeriel Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as			n occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
ne Ho 124 l ne Fu	le o i lo	(Check only 2 Medical Examiner: On the basis of examination and/or invoice) and manner stated.	vestigation, in my opinion, death occurred at the time	, date and place, and due to the cause(s)
To th within To th	Ň	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1	Julia K. ture pos	D 56611	2/14/05
(0		30. Name and address of person who completed cuse of death (I) m 23a) (Type,	Print)	/
			Ida Ave #300 Bot	hyda mp 20814
	State	31. Date filed (Month, Day Year) 32 Registrar's Signature	M .	

unpend 1tem#25a,27,18a f,perME,6842,4-1 Ensure All Copies Are Legible.

			For State Registrar	State of M	larylan	-	artment o			d Mer		ene 0	05	07769
			1. Decedent's Name (First, Middle, La							2.	Date of Deati	n Dav	Year	3. Time of Death
	Physici /Medio		Larry	Edwa	ırd	Fι	ıltz			Fe	bruary	25, 2	005	2:36 A M
	Examir		4a. Facility Name (If not institution, give				4b. City, Tov		ation of D	Death		4c. County		
			Shady Grove Adver			ast birthday)	Rockv		Jnder 24	Hrs. 8	Date of Birth	Montg		r place (State or Foreign
9	Funeral Director			1 M 2□F	57	Yrs.				Min.	(Month, Day,	1947	Goul Mai	yland
0	ס		Usual Residence of Decedent											
	arylan ahow det	<u>_</u>	10a. State 10b. County		10c. City	, Town or Lo							1	10d. Inside City Limits 1 1 Yes 2 □ No
	he M.	Director	Maryland Mont	gomery			KOCK	ville	e			og. Citizen of	What Cour	•••
	with with Liber.	급					101. 2ip C0		850					nu y :
	death ms 23	Funeral	317 Seth Place	12. Was Deceden	t Ever in U.	S. 13.	Was Decedent 1 Yes, specify			? (Specify	Yes or No-		ce - Americ	
98	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "natural", or itams 23a or 28a-f ahow event, the Medical Examinar must be notified at	y Fur	1 ☐ Never Married 2 X Married	Amed Forces 1 X Yes 2 If Yes, Give	Nec	1967	1 Yes, specity 1 □ Yes 25√2		exican, P pecify:	uerto Hic	an, etc.)	Specif	ck, White,	
Ö	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	ily 19	69	dent's Usual O					6b. Kind of 8	VVI	nite
5	in 72 n "nei	plete	(Specify only highest gr	ade completed)		(Give	kind of work d DO NOT use re	one during	g most of	f working		ieavy C		•
212	d with giene. ir thau	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Engi	neer					Constru		
b	al Hyg	Be Completed	17. Father's Name (First, Middle, Las					18.	Mother's	Name (F	irst, Middle, M	faiden Surnar	пе)	
yla	ould b Ment arkac	Jo	Louis Denver Fu								e Lewi			
Maryland 21215-0036	id 2 sh Ith and 27 is m traum		19a. Informant's Name/Relationship Vivin Johnson Fu				ng Address <i>(St</i> Seth P							
	s 1 an f Heal itam 2 othar	li	20a. Method of Disposition			lace of Dispo	sition (Name o	of		Date		20c. Location		
Ë	Page nent o int: If		1 Donation 5 Other (Speci		³ ₿alt	imore	Nation	ál Ce	emete	ery M	larch 3	, 2005	Balt	imore, MD
3altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Lice	n 11 11	MOOO	121	Name and A Keeney	and	Ract	ford	Funera	1 Home	1	
	407.40	\vdash	23a. Part1. Enter the disease, or conshock, or heart failure. List only	polications that cause	ed the death	n. Do not ent	106 Fa	st Ch	nurch	1 Str	eet F	rederi	ck,	1 21701
	enysician.		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause of each Methad	line. One Ti	ntoxic	ation	,g.			.,,,			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a Due to (or a										
	Till See	er	Sequentially list conditions, if any leading to immediate	b. Due to (or a	s a consequ	uence of):								
	outed id ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
oʻ	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or a	s a consequ	uence of):								-
8760,	ate be	dical		d									-	
9	sertific ding p	/Med	IF FEMALE:	23c. If yes, outcom	e of pregna	ncv						224 5		
Вох	eath certifi attending p	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal	death 3	Ectopic pregn Other (specif						ite of delivi onth	Day Year
P.O.	that the death cer ed by the attendin detached for use	Physiclan/Me	1 Yes 2 No 9 Unknown	9□ Unknown				//						
٥,	Attending Physician: The law requires that the death certific relath. setor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by PI	Part II. Dther significant conditions	contributing to death	but not resu	ulting in the u	nderlying caus	e given in	Part I.		23e. Did tob	acco use con	tribute to t	he cause of death?
ords	v require been sig should b									_	1 □ Ye	s 2010	3 Prob	pably 4 Unknown
မိုင	law ri as be	Completed			_					_	24a. Was ar autopsy	24b.	Were auto	psy findings available mpletion of cause of
<u>=</u>	: The tav	Con									Yes 2		death? T Yes	2□ No
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		•	heck only one			
of	ding Physician: h. After this certific funeral director,	To T	1 X Yes 2 No 27. Manner of Death	28a Date of In	iury	ER/Outpatier 28b. Time of			I 🗌 Nursii		5 Reside		341	nk
Division of Vital Records,	nding Fith.: After	Certification:	1 Natural 5 Pending 2 Accident investigation	Fnd ^{Month, D}	ay Year)	Fnd ^{njury} 2:05		Injury at Work? 1 Yes	2 X No	- 1				
N S	Attender death ector: /	ifica	3 Suicide 6XX ould not determined	28e. Place of I		me, farm, str		fice		28f.	Location (Str	eet and Numl	per or Rura	nl Route Number, h Place
Ö	italor rs afte al Dir led in	Cerl		found a	-					Ro	ckville	e, MD	set.	n Place
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		hysician: To the bes miner: On the basis and manners	of examinat									
	Fo the within Fo the	Me	29b. Signature and title of certifier	1			29c. Li	cense nun				d. Date signe		
	. 7-0		> Vandance	melshel	e m)		OCME	Ε			Februar	y 26	, 2005
			30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print) 111	Popr	n Str	root	Ral+i	more	Marzil	and 21201
			MANUANTA	3 KORET	1	Access 11 1	111	TEIII				. , .	- кат у 1	
:	St: Regist	ate rar	31. Date filed (Month, Day, Year)	2005 32 Pagis	trar's Signa	1								

			1 - For State Registrar	State of M	1 arylan		artment of			-	giene	2005	07770
	Physicia		1. Decedent's Name (First, Middle, Last CHARLOTTE L	*	RGE	R		·		2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town	, or Location		CISIQUA		County of Dea	3
			HARBOR HOS	PITAL	CEN	ITER	BALTI				В	ALTIMO	
	Funeral Director		218-22-3194	ex	76	last birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birt (Month, Da) 6-5-19	h y, Ye <i>ar)</i> 28	9. Bir C MAI	thplace (State or Foreign ountry) RYLAND
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	be filed within 72 hours after death with the Maryland with bygiene. A bygiene. A control then "naturel", or Items 23s or 28e-f show event, The Medical Examinar must be indiffed at	tor	DELAWARE SUSSE	X	MI	LLSBOR	kO						1 ☐ Yes 2 🙀 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code	•			10g. Citi	zen of What C	ountry?
	23a (23a (23a (23a (23a (23a (23a (23a (rai	26364 WINDS WAY	·			1996	6			U	S	
	or Items 23a	une	11. Marital Status	12. Was Deceder Armed Forces	?	S. 13. \	Was Decedent of Yes, specify Co	f Hispanic O uban, Mexica	rigin? (Spe an, Puerto f	cify Yes or No- Rican, etc.)		 Race - Am Black, Whi 	
50	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates	_		1□Yes 2🛛 N	lo <i>Specify</i>	<i>r</i> :			Specify:	WHITE
ş	2 hou		15. Decedent's Ed	ducation		16a. Deced	tent's Usual Occ	upation			16b. Kir	nd of Business	/Industry
2	within 7; ene. then "n	ompieted	(Specify only highest gra	completed) College (1-4o	r 5+)	(Give life. l	kind of work dor OO NOT use reti	ne during mo ired)	st of workir	19			•
7	ed wil	Con	8			HOME	MAKER					ONE	
	be fill htal H ad off	Be	17. Father's Name (First, Middle, Last) CHARLES FONK							(First, Middle,	Maiden	Sumame)	
2	Mer Mer arke	P P		Time Driet		105 14-16	- Add (Ca			ILTON	0.7	T 0:	
<u> </u>	d 2 sho th and 17 is m traum		19a. Informant's Name/Relationship (ng Address (Stre WINDS				-		Zip Code)
ā,	s 1 and if Health item 27 other tr		KENNETH FERGER/ 20a. Method of Disposition			lace of Dispo	sition (Name of			ate		Cation - City or	Town, State
E E	8 ° = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif				OPEN CR		XY 2/2	20/05	FRAN	KFORD.	DELAWARE
	nrit. Pa contrant: conjury		21. Signature of Funeral Springer Light				ESON PE					v.u.,	
n n	Depo Impo any		Charles Mil	elson)			NG NECK					WARE. 19	9966
	Physician		23a. Part I. Enter the 14 ase, or com shock, or heart Juliure. List only Immediate Cause (Final disease or condition	plications that caus one cause on each	line.	n. Do not ent	er the mode of d	ying, such a	s cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a									
		e	Sequentially list conditions,	b. Osto	SOMY	ELIT	15						14 days
Ď,	i be executed sician and burial-transit	Examin	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Decoi		SATE		NGFS	TIVE	HEA	RT 1	CAILURE	14 days
0 / p	ate hy:	dicai		_ d.									
O. BOX 6	ne death certificate the attending phys hed for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	Ideath 3□	Ectopic pregnar Other (specify)				2	3d. Date of de Month	livery Day Year
7.	that the		Part II. Other significant conditions of	ontributing to death	but not resi	ultina in the u	nderlying cause	niven in Part	ı	23e. Did to	obacco u	se contribute t	o the cause of death?
oras,	w requires that the de been signed by the s should be detached	ted by	REMAL FAILURE							1 🗆 Y	∕es 2[]No 3∏P	robably 4 🗷 Unknown
al Kecora	The far ate has page 2	Completed								24a. Was autop perfor 1 Tes		24b. Were a prior to death?	utopsy findings available completion of cause of
VITal	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				N		(Check only o			
on of	ding Phys h. After this funeral dir	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Ir (Month, L		ER/Outpatien 28b. Time of Injury	28c. In	4014	2	ne 5 🗌 Resid 8d. Describe h			ocify)
DIVISION	ipitel or Attendii burs after death. lerel Director: A filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	e 28e. Place of	njury - At ho etc. (Specif	ome, farm, str y)	eet, factory, office			8f. Location (S City or Tox	Street and vn, State)	d Number or R	ural Route Number,
	Hospite 24 hours Funeral etely fille	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the bearings: On the basis and manner	of examina	wledge, death	n occurred at the vestigation, in m	time, date a y opinion, de	nd place, a ath occurre	nd due to the o	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier				29c. Lice	nse number			29d. Date	signed (Mon	th, Day, Year)
)			> GGeorges	en M.D			P	177	91	te	EBRU	रमिट्प 1	9 2005
	1		30. Name and address of person who	completed cause o			Print)			1	1AR	CHRY 1	21221
	7.5		GEORGIANA GEORI	SELCU, 30	201500	TH HA	HOUER S	TREET	HAR	BOR, H	OSPi	TAL, By	glinore,
	Sta Registi	ate rar	GEORGIANA GEORG 31. Date filed (Month, Day, Year) FEB 2 2 2	005 32. July 1	strar's Signa	ture	me						

			Pie	ase	Type or Prin									9	
٠			FoAmend Item	<i>#</i> 5	State of Ma						Me	ntal Hy	giene	0005	07771
			- State RegistrarWCHD/SH			H	Ce	rtifica	ate of l	Death		F	Reg. No.		0////
Phy:	cicio		Decedent's Name (First, Mid.	die, Last	t)						2.	Date of Dea	ath Day	/ Year	3. Time of Death
	edic:		Armeda	Pea	arl l	Fost	er					02		0 05	21:45 PM
Exa	mine	er	4a. Fecility Name (If not instituti	on, give	street and number)	101		4b. Ci	ly, Town, or	Location of Dear	th		4c.	County of De	ath
			Sacred Heu	Ut	HOSPI	<u>rw</u>		CI	uy1	XIIW	CI			Alle	lanu
Fune	_		5. Social Security Number 212–24–1027	6. Se	TM 2427F		ast birthday Yrs.	Month	der 1 Year ns Days	If Under 24 Hrs Hours Min		Date of Birt (Month, Da	h y, Year)	1 6	dinplace (State or Foreign ountry)
Direct	or	-	Usual Residence of Decedent		21	80		<u></u>			Ax	ori1 16	, 192	4 Mar	yland
land		t	10a. State 10b. Coun	ty		10c. City	, Town or L	.ocation							10d. Inside City Limits
Mary -f sh		ğ	Florida Le	e e		C	ape	Cora	1						14 Yes 2 □ No
the 28a		Director	10e. Street and Number					10f.	Zip Code				10g. Cit	izen of What C	country?
death with the Maryland ims 23a or 28a-f show			3553 Janis	Roa	a d				3399)3				USA	•
death		Funerai	11. Marital Status		12. Was Decedent I	Ever in U.	S. 13.	Was De		ispanic Origin? (S an, Mexican, Puer	Specif	y Yes or No-		14. Race - Am	erican Indian,
after or Ite			1 Never Married 2 Ma		Armed Forces? 1 ☐ Yes 2 🛣	10					rto Hid	an, etc.)		Black, Wh	
72 hours after natural, or Ite		ğ	3 XWidowed 4 □ Divorce	ed .	If Yes, Give Year or Dates:			TUTES	2 X No	Specify:				Specify:	White
72 h natu		Completed	15. Decede (Specify only high	ent's Edi	ucation de completed)		(Giv	e kind of	sual Occup	durina most of wa	orkina		16b. Ki	ind of Busines	s/Industry
within ene. then		g	Elementary/Secondary (0-12)		College (1-4or 5	i+)	life.	DO NO	use retired	1)	_			_	
filed within Hygiene. other then			Am F al. 1 Al. 1		22		Self	Empl	oyed.	- Seams				Sewing	
d be fille		Be	17. Father's Name (First, Middle							18. Mother's Na				,	
2 should be and Mental Is marked of		၉	Ezra C.		Swain							a P.		ue	
ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If if the M215 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event.			19a. Informant's Name/Relation			1. t		_		and Number or R					
es 1 and 2 of Health		-	Linda Ande	ersc	on (Daug		lace of Disp			Road, Cap	Date			OLICA cation - City o	
Pages nent of int: If it			1 Bunal 2 Cremation			C	emetery, cre	ematory o	or other plac						
permit. Pages Department of Important: If it		}	' 4 □Donation 5 □Other							cory 2/2					n, Maryland
Dermit Pages Department of mportant: If it	ouce		21. Signature of Funeral Service	o Licens			-			ss of Facility I					ā
		-	23a Part I Enter the disease	OK COME		M-008			_	ive., Cleve		_		113	Approximate
			23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	st only o							10 01 10	ospiiatory ar	1031,		Interval Between Onset and Death
Physici /Medio			disease or condition resulting in death)	-	a. CAR			0	FL	UNG.					Imonth
Examin					Due to (or as	a consequ	uence of):								
		i i	Sequentially list conditions, if any, leading to immediate		b. Due to (or as	a consequ	uence of):								
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be executed ician and burial-transit		Exal	that initiated events resulting in death) Last		C. Due to (or as	a consequ	uence of):								
		cail		l	d										
w requires that the death certificate been signed by the attending phystholid he detached for use as the					· -										
ath cert	3	ician/Medi	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome			Oe						23d. Date of de	elivery
death of attention and for us		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live birth 4 ☐ Pregnant at			☐ Other	pregnancy (specify)					Month	Day Year
the by th		Physi	9 Unknown		9□ Unknown										
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law requires law as been signed bear signed.												1 🗆 Y	'es 2	□No 3□F	robably 427nknown
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- o - <u>-</u>	20	E											rmed? 2 E No	death?	
siclan: The certificate h		e C	25. Was case referred to medic	cal						26. Place of De	ath (C			10.0	2 2 10
Physician: this certific		To B	examiner?		Hospital:	nt 2	ER/Outpatie	ent 3	DOA Oth					6 □Other (Sp.	ecify)
ding Phy h. After this			27. Manner of Death		28a. Date of Inju (Month, Da	ry v Year)	28b. Time Injury	of	28c. Injun Worl			1. Describe h			
ath.		atio	100100111	stigation		,	injury	М		Yes 2 □No					
al or Attending Physiclan: after death. Director: After this certification by the timeral director.		Certification;	3 Suicide 6 Coul 4 Homicide dete	d not be rmined	28e. Place of Injubulding, etc	ury - At ho	me, farm, s	treet, fact	ory, office		28f	Location (S City or Tow	Street an	d Number or F	Rural Route Number,
italo rs aft	3	Ce			3,									,	
lospi hou uner		edical	29a. Certifier 1 Certify (Check only 2 Medic	ing Phy	ysician: To the best of the basis of	of my kno	wledge, dea	th occurr	ed at the tin	ne, date and place	e, and	due to the	cause(s)	and manner a	is stated.
To the Hospital or Attendition 24 hours after death. To the Funeral Director: Accompletely filled in by the fi		Jedi	One)		and manner sta	ated.	gerraktus I				J., 60				
To the second	3	2	29b. Signature and title of certif	ier	4			1	29c. License			1		e signed (Mor	
			Mulla	1	Umi				レ	2540	16		reb	ruan	17,2005
4			30. Name and address of person	1		eath (Item			,	3 1	1	4	~	0.5	
24-4			31 Date filed (Month Day You	LAN	100 32. Røgistra	De.	ton .	URIV	e (Cumber	IA	nd, n	10	2150	2
Rec	Stat istra	e ar	31. Date filed (Month, Day, Yea	3 2	005	ar a digital	B. 1	parte	0						
1100	التعنير				- English		10	/							

			1 - For State Registrar		of Ma	arylan	-	artment of I			eg. No.	05	07772
	Physici	an	Decedent's Name (First, Midd				n- 1			2. Date of Dear		248F	3. Time of Death
	/Medic	_	Emily	Mary			Forbes	41. 05. T			_		8:39 P M
1	Examin	er	4a. Facility Name (If not institution		number)				or Location of Dea Marlboro			inty of Death	
	Funeral	ų.	11609 Cheltenha 5. Social Security Number	m Road 6. Sex	7. Ag	e (In yrs. I	last birthday)	If Under 1 Year			1		
	Director		215-36-4928 Usual Residence of Decedent	1 □ M 2 X)		86	V	Months Days	Hours Min	April 4	Year) 1918	8 Mary	place (State or Foreign ntry) land
	yland		10a. State 10b. County	′		10c. City	, Town or Lo	cation					10d. Inside City Limits
	a-fel	cto	Maryland Prince	Georges	;	Uppe	er Mar	lboro	_				1 X Yes 2 ☐ No
	or 28	Dire	10e. Street and Number					10f. Zip Code		1	0g. Citizen	of What Cou	ntry?
	ath w	ral	11609 Cheltenha					20772			USZ		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or Items 23c or 28a-f show any injury or other treumatic event, the Madical Examination must be notified at anone.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma. ★★★Widowed 4 □ Divorce	ried 1 TY	i Forces?			Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🛣 No		Specify Yes or No- rto Rican, etc.)		Race - Ameri Black, White, ec <i>ify:</i> B	
ğ	2 hou	ted		nt's Education			16a. Dece	ient's Usual Occu	pation	[16b. Kind o	f Business/In	dustry
Maryland 21215-0036	d within 72 giene. r then "n	Completed	(Specify only higher Elementary/Secondary (0-12)		<i>ed)</i> je (1-4or 5	i+)	(Give life. Homer	kind of work done DO NOT use retire naker	during most of wo	orking	Dome	estic	
פַ	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle	Last)					18. Mother's Na	me (First, Middle, I	Maiden Sun	пате)	
lai	Ments Ments arked	To E	Charles	Α.		Ma	rshal.	L	Rosa		Smi	ith	
Mar	s 1 and 2 sho of Health and item 27 le ma other treums		19a. Informant's Name/Relation Peggy Proctor	ship (Турв, Print) ' / Daugh	ter		19b Mailir 1160	ng Address (Stree 19 Chelte	and Number or Renham Roa	ural Route Number id Upper I	City or To Marlbo	wn, State, Zip Dro, Maj	cyland 20772
ore.	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Demoust fr	om State	20b. P	lace of Dispo emetery, crei	sition (Name of natory or other pla	ce)	Date	20c. Location	on - City or To	own, State
Ĕ	Pag ment ent: I ury o		`4 □ Donation 5 □ Other (OIII State	Res	surrect	cion Ceme	etery 2/2	26/05	Clinto	on, Mai	cyland
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service	Cha		MO13		ans Fune		P.A. Aqı	asco,	Mary	Land
F			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications th	at caused on each lir	the death	n. Do not ent	er the mode of dy	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			M.	eta.	statil	Carl	homa		-	Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as	a consequ	uence of):		1	Breas	1		
Ь		_	Sequentially list conditions,	b	to (or as	CGY	61001	no of	The	Breasi		_	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	10 (0) 40	a conocq	abiles 51).						
	execunand and all-tra	Exal	that initiated events resulting in death) Last	c	to (or as	a consequ	uence of):						
8760,	icate be executed physician and s the burial-transit			d.									
Ó	tificat ng phy as th	led											
Вох	eath certifi attending	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome ve birth			Ectopic pregnanc	v		23d.	Date of delive	•
P.O. B	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pi	regnant at nknown			Other (specify) _	,			Month	Day Year
	res that igned b be deta	by Pt	Part II. Other significant condit	ions contributing	to death b	ut not rest	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tol	oacco use o	ontribute to t	he cause of death?
p	w require been sig should b	pa pa	Coronary	Arte	14	0,50	east			1 □ Ye	s 2 🗆 No	3 ☐ Prot	pably 4 Honknown
Vital Records,	s bec	Completed	- Coronary Hyperto	nsian	•					24a. Was a		b. Were auto	psy findings available
Ä	0 - 0	E O	1/							autops perform	ned?/	death?	mpletion of cause of 2 No
ita	yeicien: Th is certificate director, pag	BeC	25. Was case referred to medic examiner?	al					26. Place of De	ath (Check only on			2010
of <	d is	일	1 ☐ Yes 2 ☑ No		☐ Inpatie		ER/Outpatier	nt 3□ DOA Ot	her: 4 Nursing	Home 5 Keside	ence 6 🗆	Other (Specif	iy)
n O	fing Ph I. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. D	ate of Inju Month, Da	ry y Year)	28b. Time of Injury	28c. Inju Wa	ry at rk?	28d. Describe ho			
sio	Attending r death. sctor: After by the funer	cat	2 Accident inves 3 Suicide 6 Could	igation not be					Yes 2□No	00/ 1 1/ /0			
Division	el or Attend s after death if Director: od in by the	Certification:		mined 288. P	lace of Injuilding, et	ury - At ho c. <i>(Specif</i>)	me, farm, str	eet, factory, office		28f. Location (St City or Town		imber or Rura	al Houte Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 Certify (Check only one) 2 Medica	I Examiner: On the	the best ne basis of nanner sta	examina	wledge, deat tion and/or in	n occurred at the t vestigation, in my	me, date and place opinion, death occ	e, and due to the courred at the time, d	ause(s) and ate and plac	manner as s ce, and due to	tated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifi	er				29c. Licen	se number	2		gned (Month,	* * * * * * * * * * * * * * * * * * * *
			Davis.	n Has	do	ran		DOO	0437	4	2/	21/08	5
0			30. Name and address of person	who completed	cause of d	eath (Item	23a) (Type,	Print)					
1	85		DAVID M. B	OLOMA	+N	750	OHA	NOVER !	PARKWay	#105 G	REEN	BELT	mb 2077()
	Sta Registi		31. Date filed (Month, Day, Yea. FEB 2	3 2005 ³	2. Plaistr	ar's Signa	ture A	porte					mb 2077()

		State of Maryland / Department of Health and No. 2-24-05 Registrar Amend #9. Per Fam. PGC.cr. Certificate of Death	Mental Hy	giene 005	07773
Physic /Medi		1. Decedent's Name (First, Middle, Last) Vera Foster	2. Date of Dea Month	16 2005	3. Time of Death 1344 PM
Exami Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University of Mayland Medical (Enter Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min.	8. Date of Birtl (Month, Da)	4c. County of Deat 1, Year) 9. Birth Co 1955	nplace (State or Foreign Unity) Chana W.
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Prince George's UPPER MARLBORO			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ath with the 23a or 28 unt be no	Funeral Director	10e. Street and Number 10f. Zip Code 1100 Egyptian Drive 20774		10g. Citizen of What Co	untry?
1215-0036 within 72 hours after death with the Maryland ene. than "natural; or itams 23s or 28s-f show than "natural Exemination at a Modical Exemination."	ğ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1a	e, etc.
ING 21215-0036 be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or itams 23a or 28a-f show event, tre Medical Exeminer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4yrs 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Nurse.	king	16b. Kind of Business/	
Maryland 2127 1d 2 should be filed within Ith and Mental Hygiene. 27 is markad othar than traumatic evant, tra M.	To Be C	Asante Y. Akosah Akosuah	Kyerwa		
re, Mar 1 and 2 sh 1 Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Print) Richard K. Foster/Husband 20a. Method of Disposition 19b. Mailing Address (Street and Number or Run 1100 Eyyptian Drive Up			land 20774
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta important: If Item 27 is marked any Injury or other traumatic avenue.			B. Jenl	Silver Sprinkins Funera	1 Home
Pnysician /Medical Examiner		23a. Part1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	or respiratory ar		Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that imitiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
Geath certiff e attending of for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli-	very Day Year
F 5 6	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to es 2 No 3 □ Pro	the cause of death?
I Rec The law ate has b page 2 sl	e Completed	25. Was case referred to medical 26. Place of Death		sy prior to c med? death? 2 ☐ No 1 ☐ Yes	oppy findings available ompletion of cause of
//SION OT VITAI Attending Physician: 7 cleath. ctor: After this certifica	ToB	examiner? 1 Yes 2 No Hospital: DOA Other: 4 Nursing Ho	ome 5 Resid	ence 6 □Other (Spec ow injury occurred	ify)
	Certification;	4 Homicide building, etc. (Specify)	City or Tow		
the tha	Medical	29a. Certifler (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	red at the time, o	late and place, and due	to the cause(s)
Tomit		29b. Signature and title of certifier 29c. License number P18547 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHHEW Nolan mp 32 South Creen St.	F	Eb 16.3	3005
20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Nolan mp 33 South Green St. 31. Date filed (Month, Day, Year) Registrar's Signature.	Baltin	nore, m	0
St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 3 2005 Registrar's Signature			

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last.	State of Marylan	d / Depa	artment of Health and rtificate of Death	d Mental Hyg	gieme 005	07774
	Physici /Medio Examir	cal	James Thomas Gibso	n		4b. City, Town, or Location of Do	Februar	Day Year	
	Funeral Director		210-10-0037		last birthday) Yrs.	Hurlock If Under 1 Year If Under 24 Hours Nonths Days Hours N	8. Date of Birth (Month, Day Feb. 24	Dorchest Year) 9. Bi 1923 Ma	er hthplace (State or Foreign owntry) ry Land
)	e Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Talbot		y, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
3	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Madical Examiner must be mailfied at	Completed by Funeral Director	30332 Gene Gibson 11. Marital Status	12. Was Decedent Ever in U.	S. 13. y	10f. Zip Code 21601 Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pt		0g. Citizen of What C USA 14. Race - Am	
-0036	2 hours after atural', or ite	ted by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: cation		I ☐ Yes 2 🛣 No Specify:		0	lack
121215-0036	iled within 72 Hygiene. thar than "nu nt, the Medi	Complet	(Specify only highest grade Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5+)		lent's Usual Occupation kind of work done during most of to ONOT use retired) Equipment Oper	ator (Construction	•
Maryland	should be f and Mental H is marked of sumatic eval	To Be	Eugene Gibson 19a. Informant's Name/Relationship (Ty.		19b. Mailin		Name (First, Middle, I Thomas Rural Route Number		Zip Code)
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28a-1 show any injury or othar traumatic evant, the Madical Examiner must be notified at ance.		Kim James Gibson/So 20a. Method of Disposition 1 ABurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	lace of Dispo	2 Gene Gibson Ro	Date	20c. Location - City or	Town, State
Baltir	permit. P Departme Importan any Injur		21. Signature of Funeral Service Licens	J. Selle	Ze 10	urch Cemetery 2/2 Name and Address of Facility 11er Funeral Hor 6 Main Street,	me, P. O. East New M	Market, MD	
	Physician /Medical Examiner		23a. Parv. Enter the disease, or complication, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		RY	ar the mode of dying, such as card ARTERY DI.		est,	Approximate Interval Between Onset and Death
,8760,	The law requires that the death certificate be executed ste has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	·				
.O. Box 6	the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of de Month	ivery Day Year
Records, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death but not resu	llting in the un	derlying cause given in Part I.		pacco use contribute to	o the cause of death?
tal Rec	ician: The law i	e Completed	25. Was case referred to medical			OC Plans (D		prior to death? No 1 ☐ Yes	utopsy findings available completion of cause of 2 No
>	9 (7)	To B	eyaminer?	ospital: 1 ☐ Inpatient 2 ☐ B	ER/Outpatient	Othor	eath (Check only one Home 5 Reside		city) SONG RESIDENCE
Division of Vital	ing Affe	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \) No	28d. Describe ho	w injury occurred	
DIV	- 9 -		4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify, ician: To the best of my know	vledge, death	Occurred at the time, date and pla	City or Town	uso/s) and mapper as	stated
	To the Hospital o within 24 hours aff To tha Funeral Di completely filled in	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifier	er: On the basis of examinati and manner stated.	on and/or inv	estigation, in my opinion, death oc	curred at the time, da	ite and place, and due	to the cause(s)
			30, Name and address of person who con	-1MOOD; 9.	23a) (Type, F	MARKETSTI	reet; D	ENTON M	1021627
	Sta	-	31. Date filed (Month, Day FEB 2	2 2005 Registra s Signati	ure *	hosels?	/		

			1 - For State of Ma	aryland / Depa <i>Cer</i>	irtment of H tificate of L	ealth and M Death		iene 005	07775
	Physici /Medic		Decedent's Name (First, Middle, Last) WILLIAM	GEORGE	FSON		2. Date of Deal		3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERA HO 5. Social Security Number 6. Sex 7. Age	SPTUL (In yrs. last birthday)	4b. City, Town, or OLNEY If Under 1 Year	Location of Death		4c. County of Dea	MERY
	Funeral Director		215-58-9747 Usual Residence of Decedent	52 Yrs.	Months Days	Hours Min.	JUNE 29	1952 DIS	thplace (Slate or Foreign ountry) TRICT OF COL
	death with the Maryland ms 23a or 28a-f show finust be notified at	tor	10a. State 10b. County MARYLAND MONTGOMERY	10c. City, Town or Loc					10d. Inside City Limits 1 Yes 2 No
	vith the	Directo	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	ountry?
	ns 23a	Funerai	11. Marital Status 12. Was Decedent 8	ver in U.S. 13 V	20882 Vas Decedent of His	spanic Origin? (Sr	pacify Yes or No-	USA 14. Race - Am	edcan Indian
036	hin 72 hours after death with the Marylan 8. an "natural", or items 23a or 28a-1 show Medical Examinet must be notified at	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 1 Yes 2 1 Yes, Give 3 Widowed 4 1 Divorced Year or Dates:	lo	Yes, specify Cubar ☐ Yes 2 No	Specify:	Rican, etc.)	Black, Whi	
215-0036	within 72 ho ene. then "netur he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give I	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most of worl	king	16b. Kind of Business	
7	P 5 5		4	СРА				FINANCE	
yland	0 a b 8	To Be	17. Father's Name (First, Middle, Last) JAMES DEMETRIOUS GEORGESON			BETTY H			
Mar	permit. Pages 1 and 2 should the Department of Health and Ment important: if item 27 is marked any injury or other traumatic of the Dece.		19a. Informant's Name/Relationship (Type, Print) JAMES D. GEORGESON, JR - BR					City or Town, State, MD 21771	Zip Code)
ore,	or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	FEB.	Date	20c. Location - City or	Town, State
	it. Pag rtment rtant: njury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenspe	LAKEMONT M				AVIDSONVIL	
ğ	Depa Impo any l		21. Signature of Puneral Service Licenspa						L HOME, INC ING, MD 2090
	Physician /Medical		23a. Part 1. Enter the disease or comblications that caused shock, or heart failure. List entropy one cause on each lin Immediate Cause (Final disease or condition resulting in death) Due to (or as a part of the condition resulting in death)	the death. Do not ente e. C ARRITY a consequence of):	or the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death 30 M I N
	Examiner personal lister	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MYOPATHY a consequence of): 100SLS	1		*		6 MONTHS
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ras, r	w requires that the s been signed by the should be detache	by	Part II. Other significent conditions contributing to death but PNEVIMON, A. A.			n in Part I. PUVRH		acco use contribute to	the cause of death?
Records	ilcian: The law re certificate has bee rector, page 2 sho	Completed	GFVYONS, SYNCOPE				24a. Was ar autops perforn	prior to death?	utopsy findings available completion of cause of
VII	ysician: is certifica director, p	BeC	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only on	□ No □ 1 □ Yes	2 X J No
ō	Phys this al di	ion: To	1 Ves 2 No Hospital: 1 Inplanted 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Day)	y 28b. Time of	28c. Injury Work	at ?	ome 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	cify)
UNISION	il or Attending after death. I Diractor: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	ry - At home, farm, stre . (Specify)		es 2 □ No	28f. Location (Sti City or Town	eet and Number or Ri , State)	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Exeminer: On the basis of and manner sta	examination and/or inve	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	Vithir To the	M	29b. Signatuse and title of certifier		29c. License		25	d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of de STEVEN To KARY A MD I	ath (Item 23a) (Type, F	FIA AVE	#575,	WHENTON	BRUARI 1 JMD 20	902
	Sta Registr		31. Date filed (Month, Day, Year) Registra FEB 2 2 2005	r's Signature	N.				

State of Manyland / Department of Health and Mental Hytiglena / September / Se	05 R.	5-01201		CGLI	Please	Type or F							•		_	e.		
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Second Second Property Second Second Property Second				4a. Fecility Name	(If not institution, give	street and num	ber)		4b. City,	Town, or	Location of	Death		4	c. County of I	Death		
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Physician / Medical Examiner To be a so of person when the surface of person who completed cause of each surface of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of person who completed cause of	alti	ppartmit.		21. Signature of F	Funeral Service Licer	1500	. 4		2. Name aı	nd Addres	s of Facility							_
Physician Medical Examiner Figure 1 and 1		207		ya	nus E	الله الله	enu		814-	Up	se or shur	Stre	et,	N.W	.W.			
Course. Effect Underlying the property of the	1	/Medical	_	Immediate Cause disease or conditi resulting in death)	e (Final ion)	a. Que lo (c	M SNOT	+ Wore quence of):					espiratory a	irrest,		1	nterval Between	
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29b. Signature and title of certifier 29c. License number 29d. Certifier (Check only one) 29d. Certifier (Check only one) 29d. Certifier (Check only one) 29d. Certifier (Check only one) 29d. Certifier (Check only one) 29d. Certifier (Check only one) 29d. Certifier (Check only one) 29d. Certifier (Check only one) 29d. Date signed (Month, Day, Year) February 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	al Rec												auto perfo	psy ormed?	prio	to com	pletion of cause of	le
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Description of the part of the	lon	ath. rr: Aft	atio			- i	1 -			1 🗆 '	Yes 2 XV	0	Sul	ble	ctsl	ro t		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) February 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CALOL HALLOW WA 111 Penn Street Baltimore, Maryland 21201	Divis	I or Atte after de Diracto	ertific			286. Place	of Injury - At h g, etc. (Speci	ify) ,		,	+	281	Location (City or To	Street a	ind Number of	Rural	Poute Number, evalle Re	d
The Caral Hallam was and address of person who completed cause of death (Item 23a) (Type, Print) CAROL HALLAW was 111 Penn Street Baltimore, Maryland 21201		a Hospita 24 hours a Funeral etely filled		(Check only	1 Certifying Ph	niner: On the ba	sis of examin-	owledge, deat	th occurred	at the tim	ne. date and	place, and occurred	due to the at the time,	cause(:	s) and manne	r as stat	ted	_
The Caral Hallam was and address of person who completed cause of death (Item 23a) (Type, Print) CAROL HALLAW was 111 Penn Street Baltimore, Maryland 21201		To the Within To the compli	Me	29b. Signature an	d title of certifier				29	c. License	e number			29d. D.	ate signed (A	fonth, D	ay, Year)	_
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		1		CAR	02 H/	completed cause	of death (Ite					eet	Balti					
	•			31. Date filed (Mo	EB 2 2 2	105 32/Re	gistrar's Sign	ature do	ande									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylar		nent of Health and	Mental Hygie	enez n n 5	07777
			Registrar		Certific	cate of Death		. No.	0////
	Physici	an	Decedent's Name (First, Middle, Last)) - C.	- 11		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a Facility Name (If not institution, give s	Street and number)	ett.	City, Town, or Location of Dea	10 ol - a	4c. County of Deat	19:35 PM
	Examir	ler	Peninsua Regional	Medical Co.	oter.	Salisburg		Wicine	
	Funeral		5. Social Security Number 6. Sex		last birthday) If U	Inder 1 Year It Under 24 Hrs		9. Birt	holace (State or Foreign
	Director		273-12-0071	M 20 F 73	Yrs.	nths Days Hours Min		32 1	untry)
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location	1			10d. Inside City Limits
	Many Fied a	tor	md Warres	ter Pa	- 1	e			1 XYes 2 □ No
	or 28e	irec	10e. Street and Number			f. Zip Code	10g	. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28e-f show r.r.ust be retified at	raiD	1210 Market S	treet AD	t. A-5	21851		U.S.A.	
		Funeral Director		12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was D If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	rican Indian,
39	ours after death with the Marylan ral', or Items 23a or 28e-f show Examiner must be restified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 □ Y	es 2 No Specify:		Specify: R	1001
# 1/2°	72 hours after "netural", or Ite	ted	15. Decedent's Educ	cation	16a. Decedent's	Usual Occupation	16	b. Kind of Business/	Industry
21215	within 7 ene. than "r	Completed	(Specify only highest grade	College (1-4or 5+)	life. DO NO	of work done during most of wo OT use retired)	rking		
250	Hygier Hygier ther th	Co	8-th grade		Janita	orial Serv	ices L	I, M, E,	5,
and	should be filed withly and Mental Hygiene. marked other then matic event, Its M	To Be	17. Father's Name/(First, Middle, Last)			18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
Doris 245 Maryl	2 should and Mer Is marke sumatic	10	19a. Informant's Name/Relationship (Ty)	On (e	19h Mailing Add	dress (Street and Number or R	e WOO	pland	S- Code)
-	nd 2 state are alth ar 27 is r treu		Sherry Raine	es Cfriend	P. O. R.	a allow t		27212	ip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hi Department of Health and Mental Hygiene Importent: if Item 27 is marked other than "netu any injury or other treumatic event, it a Neulcal ODCS.		20a. Method of Disposition	20b. F	Place of Disposition cemetery, crematory	(Name of corother place)	Date 20	c. Location - City or	Town, State
<u>Ë</u>	nit. Page partment or ortent: If injury or		1 Denation 2 Cremation 3 R '4 Donation 5 Other (Specify)	emovar nom state			5-05 W	les tour	- md
Salt	permit. Departimpo		21 Signature Transfer ral Service License	10 PC	22. Nam	ne and Address of Facility B	wie Sm	th fun	cal Home
	0 D 7 € Ø		Xorsell	Joe	Y, U:	13020 35 / PO	comoke (144,	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	th. Do not enter the	mode of dying, such as cardia	c or respiratory arrest	. /	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	- Metastatie	hy	ing cances			oneyers
	Examiner			Due to (or as a consec	quence of):				
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	juence of):				
	ecuted and transi	Examiner	that initiated events cresulting in death) Last						
68760,	ficate be executed physicien and s the burial-transit	ai Ey	resulting in death) Last	Due to (or as a conseq	luence of):				
587	ficate phys s the	edicai	d						
Вох		υ/Με	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		-		23d. Date of deliv	(80)
m.	death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta 4 Pregnant at time of d		r (specify)		Month	Day Year
P.O.	at the by th	hys	9 Unknown	9□ Unknown					
8	Attanding Physicien: The law requires that the death cert in death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use.	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlyi	ing cause given in Part I.		co use contribute to	
oro	requi	Completed					1 Yes	2∐No 3∏Pro	bably 4 DUnknown
Зес	has b	mpi					24a. Was an autopsy performed	24b. Were aut prior to co	opsy findings available ompletion of cause of
[2]	ticien: Th certificate rector, pag		25. Was case referred to medical				1 Yes 22	No 1 Yes	2 🗆 No
<u> </u>	ysicien: The la is certificate has director, page 2	To Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	th (Check only one)	o 6 DOthor (Spee	(4.)
0	ng Phys ter this neral dii		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		ny)
<u>S</u> .	lendir eath. or: Al	catic	2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M	1 Yes 2 No			
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa	ctory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
	purs a cours a filled filled	al Ce	29a. Certifier 1 Certifying Phys	ician: To the heat of my key	wiedge dooth assure				1
	e Hos 24 h e Fun letely	Medical	(Check only one)	ner: On the basis of examina and manner stated.	ition and/or investiga	rred at the time, date and place tion, in my opinion, death occu	e, and due to the caus arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Me	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month,	Day, Year)
			me various			D057359	Fee	sigary 21st	2005
~	110		30. Name and address of person who cor					1-4	
	7,2		DR. USITA NATES AT	V 1415 S. 1	DIVISION S	T, SAUSBURY, 1	40×101		
	Sta Registr	te ar	31. Date filed (Month Pay Year) EB 2 2 20	32. Tegistrar's Signa	H. Sorrel	W.			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Dev Year **Physician** Luther Emory Griffith February 2005 12:50 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Julia Manor Hagerstown Washington If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Months Hours 1⊠ M 2□ F Yrs. 219-20-4834 Feb. 26,1927 Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Washington Directo Maryland Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Dapartment of Health and Mantai Hygiene. Important: If them 27 is marked other than servinjury or other traumer. 401 South Potomac Street 21740 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Merried 2 → Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Fabricator Fairchild Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Earl Lee Griffith Virginia Haycock Griffith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Laura Griffith/Wife 401 South Potomac St. Hagerstown, Md. 21740 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2/25/2005 Hagerstown, Maryland 21. Signature of Funeral Service Cicensee 22. Name end Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Nedical Examiner Due to (or as a consequence of): Examiner bunal-transit Attanding Physician: The law raquiras that the daath certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last physician and Division of Vital Records. P.O. Box 68760. by Physician/Medical attending physic I for usa as the b Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? is certificata has been signed by tha director, page 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed TLIYES 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3□ DOA this tor: After this 28a. Date of Injury (Month, Day Year) 28c. 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Injury at 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.
To the Funersi Director: A completaly filled in by the ft death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) end manner stated 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier DOO 60336 0 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1126 opal ARIN war SHET 21740

DHMH 16 Rev 6/95

State Registra

31. Date filed (Month Pay Yeer) FEB 2 3

32. Registrer's Signeture

			For State Registrar	State of N	Maryland / Depa	artment of H			giene 005	07779
	ee '		1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea		3. Time of Death
	Physici		Edward S	Savre	Goldstein		ļ.	Month Pebruary	Day Year v 22. 2005	1309 M
	/Medi Examir		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death	COLUM	4c. County of De	
	Exami		PENINSULA REGIO	NAL MEDICAT	CENTER	SALISBU	IRV		WICOMIC	0
	Funeral		5. Social Security Number		Age (In yrs. last birthday)	If Under 1 Year		8. Date of Birth		irthplace (State or Foreign
	Funeral Director		181-20-8164	1 🔀 M 2 🗆 F	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Pay 3/20/19	(1) Year) (2) Pon	nsylvania
			Usual Residence of Decedent					3/20/1	20 [CII	iisyivaiita
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar Mar	ţō	Maryland Word	ester	Ocean C	City				1 ☐XYes 2 ☐ No
	288 Prof	rec	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of What 0	Country?
	3a o	D	209 Trimper Av	æ.		21842	2		USA	
	leath rns 2	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Spe	cifv Yes or No-		nerican Indian,
10	r ther	F	1 ☐ Never Married 25 Marri	ied Armed Forces	7 No	If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puert <i>o I</i>	Rican, etc.)	Black, Wh	ite, etc.
930	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	Marines	1 ☐ Yes 2 ☑ No	Specify:		Specify:	white
21215-0036	72 hours after death with the Maryland natural; or tems 23a or 28a-f show dical Exsolier must be muilfied at	ted		t's Education	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
715	within 7 iene. than "n	Completed	(Specify only highe: Elementary/Secondary (0-12)	st grade completed) College (1-4a)	life.	kind of work done of DO NOT use retired,	luring most of workir)	ng		
21;	d with	E O	12	4		Developer	•		Land Deve	lopment
D	e filed I Hygir othar	Be C	17. Father's Name (First, Middle,	Last)		- LI GILDE	18. Mother's Name			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heathh and Mental Hyglene. itam 27 is markad other than "natural", or ttems 23a or 28a-f show other traumatic avant, if e M-dical Exa. it is to matte by notified at	ToE	Bernard Golds	tein			Rosalyn	Wolfsc	on	
lar	2 sho and is ma		19a. Informant's Name/Relations						r, City or Town, State,	Zip Code)
	1 and Health tam 27 tam 27 other tra		Mae Goldstein/w				e., Ocean			
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Stat	8	matory or other place	θ)		20c. Location - City of	r Town, State
Ξ.	Pag ment ant:		`4 ☐ Donation 5 ☐ Other (S		Beth Isra	ael Cemete	ery 2/2	5/05	Salisbury	, MD
Ball	permit. Pages 'Department of the Important: If its any injury or of section in the interpretation of the injury or of section in the injury or other injury or		21 Sunature of Funeral Service	Licensee	22 H	2. Name and Address Olloway F	s of Facility	me Prof	essional A	Association
	O D E 4 3		Noure H.	Jampson	CFSP 5	01 Snow H	Ill Rd.,	Salisbu	ry, MD 218	304
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not ent line.	er the mode of dying	g, such as cardiac or	r respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 1	JUNTIORQA	را جمه د	UNE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of):		CON CA			
	LAGIIIIICI		Sequentially list conditions,	b	Wardson	Wc (0)	CON LA	MCGR		
	be sit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (sar a	s a consequence of):			,		
	and -tran	кап	that initiated events resulting in death) Last	C. Dua to (or a	is a consequence of):					
8760,	death certificate be executed e attending physician and at for use as the burial-transit		, , , , , , , , , , , , , , , , , , ,	Due to (or a	is a consequence on).					
87	physi physi the b	Physician/Medical		d.						l l
9 ×	eath certitic attending p tor use as t	/Me	IF FEMALE:	220 If you gutoem	o of orognossy			-		
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
0.	at the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		Other (specify)				
٥.	that the		Part II. Other significant condition	Ins contributing to death	but not resulting in the u	nderhing cause give	on in Part I	23e Did to	hacco use contribute	to the cause of death?
ds,	og pe	by	Tarris enter engineering	or some source	but not rosuming in the u	ndonying oddoo givo	orran arci.		es 2 No 3 F	
ecords,	w requir been si should	Completed				-				
ec	e law has t	npie						24a. Was a autops	y prior to	utopsy findings available completion of cause of
œ.		S						perform 1 ☐ Yes	med? death? 2 ☑ No 1 ☐ Ye	
Vital	ician: certific	Be	25. Was case referred to medica examiner?	/			26. Place of Death	(Check only on	e)	
of \	lis dir	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa			4 Nursing Hon	ne 5 🗆 Reside	ence 6 Other (Sp.	ecify)
		iuo	27. Manner of Death 1 ☑ Natural 5 ☑ Pendin	28a. Date of In (Month, D	jury 28b. Time of Injury	28c. Injury Work	at 2	8d. Describe ho	ow injury occurred	
sio	Attanding r death. ector: After by the fune	cati	2 Accident investi	gation		M 1 1 Y	/es 2□No			
Division	l or Atl atter d Direct	Certification;	3 ☐ Suicide 6 ☐ Could determ	ined 286. Place of I	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	2	8f. Location (SI City or Town	reet and Number or F n, State)	lural Route Number,
	pital or Al ours after of leral Directilled in by									
	Hos Fur Fely	edical	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the bes Examiner: On the basis	st of my knowledge, death of examination and/or in	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	nd due to the co d at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the Hos within 24 h To tha Fur completely	Med	29b. Signature and title of certifie	and manner s	stated.	29c. License	number	2	9d. Date signed (Mon	th Day Year)
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State of Maryland / Department of Health and Mental Hygien [] [] 5

Amend Item 30, per Verb., 6842; 04/14/95dh 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** FEBRUARY 22, 2005 12:15 PM MAE E. HARRISON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S GRASONVILLE HEARTLAND HOUSE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🗙 F Yrs. JAN. 7, 1921 MD 84 220-12-0062 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County ahow 10a. State ns 23a or 28a-f ahov must be notified at 1 ☐ Yes 2 No Directo TALBOT ST. MICHAELS MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 106 EAST CHEW AVENUE 21663 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 ō Specify: þ 3 XWidowed 4 ☐ Divorced 'natural' Completed d other then 'nature 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other ther HEALTHCARE PRACTICAL NURSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mental F Be **GRACE SEWARD** HUGH T. HARRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29164 HOLLY ROAD, EASTON, MD 21601 RENA DYE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō = 5 WOODLAWN MEMORIAL PARK permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 02/26/2005 EASTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Betw Onset and Death Immediate Cause (Final CANCER OF LUNG **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HGAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dis o (or as a consequence of): Examine anding physician and use as the burial-transit The law requires that the death certificate be executed COrour Due to (or as a sequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death been signed by the s should be detached P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pernomed 1☐ Yes 2☑ No 1 Yes 2 ☐ No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28c. Injury at Work? Hom 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 127055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joel H. Wilkerson, MD, Heartland House 31. Date filed (Month, Day, Year) FEB 2 3 32 Registrar's Signature State 2005 Registrar

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		•	1 - State Registrar	Cer	rtificate of D	Death	Reg.	CUU-3	0//81
	Physicia		1. Decedent's Name (First, Middle, Last)			2.	Date of Death Month	Day Year	3. Time of Death
	/Medic		Grayson Lee Hurley		4b. City, Town, or	Location of Death	bruary	16 200: 4c. County of Deal	
	Examin	er	4a. Facility Name (If not institution, give street and number)	1001/	40. City, Town, or i	a biode =	/	Dorche	ector
	Funeral		Dorchester General Ho 5. Social Security Number 6. Sex, 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye	9. Birt	thplace (State or Foreign
	Director		220–32–9344 ^{↑™ 2□ F} 67	Yrs.	Months Days	Se	ept. 26,	1937 Ma	aryland
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, Ci	ity, Town or Lo	ocation				10d. Inside City Limits
9	Maryla 1 sho	jo	MD Dorchester	Eas	st New Mar	ket			1 ☐ Yes 2 No
2	r 28a	rec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
7	23a c 23a c ust bs	by Funeral Director	5611 Ryan's Run			21631		U.S.A.	
2	er dez Items	nue	11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	J.S. 13. \	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify n, Mexican, Puerto Ric	/ Yes or No- an, etc.)	14. Race - Ame Black, Whit	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Manrial Hygiene. If Health and Manrial Hygiene item 27 Ia marked other than "natural", or flems 23a or 28a-f show other traumatic evant. If a Medical Economic must be redifficed and		1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: W	nite
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	and sealth m 27		Faye Hurley wife		D. Box 265 osition (Name of	East Nev	-	, MD 216 Location - City or	
Baltimore,	Pages 1 nent of H int: If ita iry or ot		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	matory or other place	e)			
Itin			. 4 □ Donation 5 □ Other (Specify) Eas 21. Signature of Funeral Service Licensee		Market Cen 2. Name and Addres	n。(2/21/0 s of Facility Thon			arket, MD
Ba	permit. Departr Imports any inju		Buck	MD 21613					
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ith. Do not ent	ter the mode of dying	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CA	reh th	Min			Onset and Death
	/Medical Examiner		resulting in death) Due to for as a conse	quence of):	- 1	1111000			6 MOD.
		ē	Sequentially list conditions, in any, learning to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	e circo	LILOVV 1-1	-		W VICO
	cuted od ransit	Examiner	that initiated events C.						
760,	certificate be executed rding physician and use as the burial-transit		resulting in death) Last Due to (or as a conse	quence of):					
6876	physic physic the b	dlcal	d						
Вох	death certificate b attending physic d for use as the t	by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregram		75-1			23d. Date of de	•
-	death ne atter ed for u	sicla	in the past 12 months? 1 Ves 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
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			30. Name and address of person who completed cause of death (Ite	am 23a) (Type.	, Print)	0.11.00	nue 1	hobel 1	2005 nd 21643
			31. Date filed (Month, Day-Year) 2 20032. Registrar's Sign	nature .	30%	COLLING	100 17	witch !	114 71643
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miner	r	4a. Facility Name (If not institution 616 Camden Av		Der)		4b. City, Town, or			40.		y of Death	_
ral		5. Social Security Number		7. Age (In yrs. I	last birthday)	Salisb If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth		COMic 9. Birthp	place (State or Fore
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		20a. Method of Disposition 1 □ Burial 2 X Cremation		itate C	emetery, crem	natory or other place	9)	Date			- City or To	
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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<u>ya</u>	Men Men Marke	ြ	Thomas M. Hesle	·•			,	Flore							
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Бащтог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Immortant: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic svent, the Medical Examination and page.		 4 □ Donation 5 □ Other (Sp 21. Signature of/Funeral Service) L 		Metropol				2005	-	Alexand		Virgi	nia	
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			231. Pa 11. Enter the disease, or shock, or heart failure. List of	complications that cau only one cause on eac	sed the death. Do no h line.	ot enter the mod	le of dying,	, such as c	cardiac or r	espiratory arr	est,		Approximat Interval Bet	ween	
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	To the Hospital or Attending Ph within 24 hours atten death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Medical E	xaminer: On the basis	s of examination and/	or investigation	in my opir	nion, death	occurred	at the time, da	ate and place,	and due to	the cause(s)		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2:20 P Hirrlinger February 20,2005 Patricia Α. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 6920 Horizon Terrace Derwood Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X□ F Yrs Director 578-34-7907 76 1928 Washington, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worle r than "natural", or Itams 23a or 28a-f ehov The Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3710 Everton Street 20906 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other th
any Injury or other traumatic evant. The Office Manager County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John E. O'Connor Jean Lowery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Schaeffer/ Daughter 6920 Horizon Terrace, Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State February 23, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Q * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. ocee 500 University Blvd, W., Silver Spring, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Friysician a. Lung Cancer 15 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1X Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? 1 ☐ Yes 2 ☐ No 1 🔲 Yes 2 X No To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Paughter's Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature a 2/2/105 U54378 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) Cheryl Aylesworth, M.D. 2730 University Blvd, West, #400, Wheaton, MD 20902 31. Date filed (Month, Day, Year) FEB 22 32 Registrar's Signature 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18, RUBYE HAYWARD FEB. 2005 4:20 A M CRAWFORD /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Months Hours 1 ☐ M 2 X F Yrs. **Director** 79 092-20-0739 JAN. 18,1926 **NEW YORK** Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD. MONTGOMERY SILVER SPRING 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 INTERNATIONAL DR. #521 20906 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: ð Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 le marked other than any injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) P.G.CO. SCHOOL TEACHER PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CRAWFORD WILLIAM NELLIE MAE McBROOM 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAROLD W. HAYWARD/HUSBAND 3701 INTERNATIONAL DR. #521, SILVER SPRING, MD. 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) b CHAMBERS CREMATORY | 2-22-2005 RIVERDALE, MD. 21. Signature of Funeral Service Ansee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. Will M00091 5801 CLEVELAND AVE, RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entail Uncorpured Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death ρģ in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed certificate Yes 2□No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signardia and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 ess of persop who completed cause of death (Item 23a) (Type, Print) D. 18101 PRINCE Philip DR, OLNEY, MD 20852 CHAE 31. Date filed (Month, Day, Year) FEB 2 2 State 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** LORRATNE HEROLD P^{M} LTLA February 2005 5:45 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 212 Dale Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 30, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🖾 F 83 555.42.1839 South Dakota Director Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Montgomery Silver Spring Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Dale Drive 20910 U.S.A. or Itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Yes, Give Specify: ò If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willette Lila Komrosky Thomas ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Dale Drive, Silver Spring, Maryland 20910 Julie Mills/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 2/20/2005 Brentwood, Maryland injury ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 'n Name Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or had failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): Examiner O. P. D. Sequentially list conditions, Due to or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2⊠ No Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 TYes 2 🗆 No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 🔯 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18/05 The, mo D-22840 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hazel Scott McGee, M.D. 1396 Piccard Drive, 2nd Floor, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) FEB 2 2

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State Registrar

	·	1 = For State Registrar		Marylar		artment of H			Reg. No.	07787
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neral		5. Social Security Number	6. Sex 7 1 ☐ M 2X F		last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi			irthplace (State or Fores Country)
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Important: Iritiam 27 is marked other than Thatulat, or itams 25s or 25s-1 show any injury or other traumatic avant, the Modical Examiner mast be notified at 2005s.	by Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	Country?
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	by	3. Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:	ļ	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
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nati	유	19a. Informant's Name/Relations			10h Mailie	an Address (Street			er, City or Town, State,	Zio Codo
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hert		Sheila J. Yec	k/ Daughter				Mount Wa		on, MD 2090	
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led for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 ☐ Feta nt at time of c	ıldeath 3□	Ectopic pregnancy Other (specify)	1		23d. Date of do Month	elivery Day Year
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pinous	Completed					Jan J _ Domen	· · · · · · · · · · · · · · · · · · ·	04- 145-	045 11/1-1-1	
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page	Ş							1 ☐ Yes		
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funeral director,		27. Manner of Death	28a. Date of (Month)	Injury	28b. Time of	f 28c. Injur Wor	y at	28d. Describe	how injury occurred	
	ti	1 X Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Worth)	, Day 16ai)	Injury		Yes 2 □ No			
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=	erti	4 Homicide	building	g, etc. (Speci	fy)			City or To	wn, State)	
Jeny more	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the base	sis of examina	owledge, death	h occurred at the til vestigation, in my o	me, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
<u>w</u>	Wed	29b. Signature and title of certific		stated.		29c. Licens	e number		29d. Date signed (Mor	oth Day Year
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			100			1,000	7 4		February	21, 2005
dwoo		30. Name and address of person	who completed cause	of death (Iter	m 23a) (Type,	Print)				
ompletely filled in by the		30. Name and address of person Mahmoud Ha 31. Date filed (Month, Day, Year FEB 25	ii Docki M		.299 La		Drive, S	Silver Sp	oring, MD 20	0902

			1 - For State Registrar	State o	of Maryla		artment of F rtificate of a		Mental Hygi	en(è () () 5 g. No.	07788	
		Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death	
П	Physici		Estella Irene HAUSE						Month Feb. 19	Day Yea 2005		
م محص	/Medio Examir											
	LXamii	101	Clearview Nursing Home				Hagerstown			Washington		
	Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday) If Under 1 Year If Under 24 Hrs		8. Date of Birth	8. Date of Birth (Month, Day, Year) 9. Birthplace (S			
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	aryle shov	<u>_</u>	10a. State 10b. County		100. 0	City, Town or Lo	cation				10d. Inside City Limits 11☑ Yes 2 ☐ No	
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	with t	Funeral Dir							g. Citizen of What	Country?		
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8	within 72 hours effer deeth with the Maryland ene. than "natural", or itams 23a or 28a-f show ha Madical Examinar must be notified at	δ	3 ☑ Widowed 4 □ Divorced	If You Gi	ive -		1□Yes 2X No	Specify:		Specify:	White	
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2	or th	S	12	0		Se	cretary			Aircraf	t	
2	d oth	ToBe	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, M	aiden Sumame)		
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manylen Depertment of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or itama 23s or 28a-f show any fujury or other traumatic avant, the Madical Examinat must be notified at ance.											
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وّ	or of		12 Burial 2 ☐ Cremation		State	cemetery, cren	natory or other plac	1				
altimore,	it. Pertine		* 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Re	st Have	n Cemete	ry 2/2	3/05 <u>H</u>	agerstown	n, Maryland	
Ba	Depermine Depermine Important Information Series Concession Concession Series Conces		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740									
	/Medical be executed // // // // // // // // // // // // //	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
)			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Attwo Schwitz Cald Overward actions Attwo Schwitz Cald Overward actions									
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	withir To the Comp	Σ	29b. Signature and title of certifie		_		29c. License	number	290	I. Date signed (Mor	* * * * * * * * * * * * * * * * * * * *	
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			30. Name and address of person	who completed caus	se of death (Ite	m 23a) (Type, I						
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	n		Decedent's Name (First, Middle, Last)						2	2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic	al -	John Patrick Hunt						F	ebruary	20	2005	
	Examin	er	4a. Aacility Name (If not institution, give street	at and number)	α_{i}	4b. City, T	own, or L	ocation of	f Death	/		ity of Death	
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п	Funeral Director		116-22-0347	2□F 7. Age (iii yis. last	Yrs.		Days	Hours	Min.	Date of Birth (Month, Day ug. 12,	Year)	New	place (State or Foreign ntry)
			Usual Residence of Decedent							ug. 12,	1930	HEW	TOLK
	arylen show	_	10a. State 10b. County	10c. City, T	own or Loc	ation							10d. Inside City Limits 1 ☐ Yes 2 No
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	with the	Funeral Director	10e. Street and Number	D1		10f. Zip (5 0		1	log. Citizen o		ntry?
	ns 23	eral	314 Lakeside Drive,	Was Decedent Ever in U.S.		las Decede	199		nin? /Sneci	fy Yes or No-	U.S	.A. ace - Ameri	can Indian
(0	r iten	F	1 Never Married 2 Married	Armed Forces? IETYes 2 □ No					Puerto Ri	fy Yes or No- can, etc.)	В	lack, White,	etc.
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d 2			17. Father's Name (First, Middle, Last)		CIITEI	Lingt			r's Name (First, Middle,		ame)	
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ary	should and Men Is marke eumatic		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing	g Address ((Street ar			Route Number	r, City or Tow	m, State, Zip	Code)
	1 and 2 Health a tam 27 is		Marie Hunt / Wife						, Pla	ntation	ns Eas	t	
ore	00		20a. Method of Disposition 1	20b. Plac cem	e of Dispos etery, crem	ition (Name atory or oth	e of her place,	,	Da	te	20c. Location	n - City or To	own, State
Baltimore,	Pages tment of tant: If It jury or o		* 4 ☐ Donation 5 ☐ Other (Specify)		Saint			_					New York
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Division	l or Attender death of the Cor.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	 Place of Injury - At home building, etc. (Specify) 	e, farm, stre	et, factory,	office		28	If. Location (S City or Tow		mber or Rura	al Route Number,
	pital		29a. Certifier Certifying Physicia	an: To the best of my knowle	adae dest	Opposed -	** * * * * * * * * * * * * * * * * * *	n deta ar	d place a	d due to the	21100(=)		tatad
	To the Hospital or At within 24 hours efter of To the Funeral Direct gompletely filled in by	Medical	(Check only 2 Medical Examiner:	On the basis of examination and manner stated	n and/or inv	estigation,	in my opi	inion, deat	th occurred	at the time, o	late and place	e, and due to	o the cause(s)
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17	2 MP		17/1/-				D5:	542	2		DY	2//=5	
1	IVA		30. Name and address of person who comp	leted cause of death (Item 2	3a) (Type, f	Print)	- 1.	/			7/80/		
	Str	ate	31. Date filed (Month, Day, Year)	32. Poistrar's Signatur	9// 5	<i>r</i> . 5	xali:	5DU (4.1	nva	11801		
	Regist		FEB 2 4 200	leted cause of death (Item 2:	X A	north	,						

			For	State of Ma		d / Dep	artment	of Health		-	•) S	07700
			1 - State Registrar			Ce	rtificate	of Deat			g. No.	00	01130
	Physicia	an	Decedent's Name (First, Middle, Language)							Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	GRANVIL EVERE		I SR.		4h Ciby To	own, or Location		bruary		2005 Ity of Death	1000 M
	Examin	er	WASHINGTON COUNT				40. Oity, 10		RSTOWN			WASHIN	TCTON
	Funeral		Sociat Security Number 6.	Sex 7. Age	e (in yrs.	last birthday)	If Under 1	Year If Unc		Dete of Birth (Month, Day,			place (State or Foreign oftry)
н	Director		215-14-2568	1⊠M 2□F	_82	Yrs.	Months [Days Hour	s Min.	$\overline{\text{JNE } 13}$	1922	MA	RYLAND
	pur *		Usuat Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or L	ocation					1	0d. Inside City Limits
	Maryla f sho	5		INGTON		,,		SHARPS	ים וותר				1 ☐ Yes 2 No
	28e-	Director	10e. Street and Number	LINGTOIN			10f. Zip C		DUNG	10	g. Citizen o	of What Cour	ntry?
	h with	a D	2244 DARGAN ROAD					2178	32		П	.S.A.	
	ems (Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13.	Was Deceder		Origin? (Specify can, Puerto Rica	Yes or No-	14. Ra	ace - Americ lack, White.	
36	s after or it	by Fu	1 Never Married 2 Married	1 ⊠Yes 2 □ N	№ 194	3-	1 □ Yes 2 1			,	Spec	ifv.	
2-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel" or tems 23a or 28a-f show int, the Madical Examinar must be mutified at	pa p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	194		dent's Usual (Occupation		1	Sh Kind of	Business/In	HTE dustry
5	nin 72 n "ne Medic	Completed	(Specify only highest g	rade completed)	:.)	(Give	kind of work DO NOT use	done durina n	nost of working	,	ob. Mila of	Du3#1633/111	austry
212	d with giene	E	Elementary/Secondary (0-12)	College (1-4or 5)+)		CUST	CODIAN			FEDER/	AL_GOV	ERNMENT
<u> </u>	be file ital Hyg id othe event,	Bec	17. Father's Name (First, Middle, Las	t)			01	18. Mo	other's Name (Fi				
<u> a</u>	Menti Menti arked arice	5	JESSE A. INGRAM					FAY	E IRENE	TAYLO:	R		
Maryland	2 sh and is m reum		19a. Informant's Name/Relationship			1			mber or Rural Ro		•		
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If the strain and Mental Hygiene is the strain at the strain of the strain of the strain at the modified at other treumatic event, the Medical Examinating the modified at		V. VIRGINIA INGR. 20a. Method of Disposition	AM/SPOUSE	20b. F		HARPEL osition (Name		RY ROAD,			MARY	TLAND 21782
Baltimore,	Pages nent of thint: If its int: If its		1 ⊠ Burial 2 ☐ Cremation 3		0	emetery, cre	matory or other	er place)	1			•	
를			' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Fun, all Section Lice		SAM			EMETER Address of Fa					MARYLAND
Ba	permit. Departr Importe any inju		TIES	pelly A. Zi	immer	B		NERAL H	IOME 'O	06 01d onsbor			
			23a. Pan1. Enter the disease, or con shock, or heart failure. List on	nplications that caused	the deat		ter the mode	of dying, such				Lyland	Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	D									Onset and Death
П	/Medical		resulting in death)	a. Due to (pr as	a cpnseq								1 weeks
	Examiner		Sequentially list conditions	b. Stra	ke								years
	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a curisey	uence of).							Vp.
	and and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or as	705c	Leros	A					-	1 cars
760,	ate be executed nysician and he burial-transit	calE		Deal	Let	2	m. U	tu					years Years
	fficate g phys			_ d	7.1.0		7. W-C						7 4115
X	ires that the death certific signed by the attending p d be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			75-4				23d. D	Date of delive	эгу
Vital Records, P.O. Box	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			□Ectopic preg □ Other (spec				٨	Month	Day Year
o. O	at the I by th	Phys	9 Unknown		-								
Ś	res th signed be d		Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	inderlying cau	ise given in Pa	art I.		accouse co 2 □ No		ne cause of death?
0.0	w requir been si should	eted	20/25	1			_	-					
3ec	has has by	Completed	- Degmen	My						24a. Was an autopsy			psy findings available mpletion of cause of
a	n: Th ficate nr, pag	e Co	25. Was case referred to medical							perform		1 ☐ Yes	2 No
ž	s certi	100	examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpatie	nt 3 DOA	Othor	ace of Death (C Nursing Home			ther (Specifi	w)
Division of	g Phy er this eral c	n: To	27. Manner of Death	28a. te of Inju (Month, Da	ry	28b. Time o		. Injury at		. Describe hov			y)
0	ath. rr: Aft	atio	1 Natural 5 ☐ Pending 2 Accident investigati	on	y 1 0 a1)	Injury	М	Work? 1 ☐ Yes 2	□No				
ivis	or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Injuding, etc	ury - At h	ome, farm, st	reet, factory,	office	28f.	Location (Stre City or Town,		mber or Rura	l Route Number,
Ω	urs afi rel Di												
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the best aminer: On the basis of and manner sta	f examina	wledge, dea tion and/or ir	th occurred at evestigation, in	the time, date n my opinion,	and place, and death occurred a	due to the car at the time, da	use(s) and r te and place	manner as si e, and due to	tated. the cause(s)
	o the o the omple	Me	29b. Signatureland title of certifier	and marrier ste			29c. l	License numb	er			ned (Month,	
	⊢ s ⊢ ŏ		1 Down 2	1			7) 449	96		Foh-	U2v4	20,2005
			30. Name and address of person wh	o completed cause of d	leath (Iter	n 23a) (Type					OL/ 1		
SI	1-4+1		Zafar Malik, M.	D. 20311	Lapr	ans R	oad, Bo	oonsbor	o, Mary	1and	21713		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	iture	4						
	Regist	rar	The Market State of the State o	- JAKEU	-	5. jaj	and I						

				25 State of Ma per Veri	aryland / 5, G842,	O471	itment of I 5/05dhb tificate of	lealth ar Death			2005	07791
	Physicia /Medic	an	1. Decedent's Name (First, Middle JUNE E.	JOHNS	ON					Date of Death Month	Day Year	3. Time of Death 5 10 10 A M
	Examin		4a. Facility Name (If not institution UNIVERSITY OF	MARYLAND				LTIM	ORE.		NAB	PALTIMORE
	Funeral Director		5. Social Security Number 214-66-7858	6. Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. last b 48	rirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Min. F	Date of Birth (Month, Day, Yea eb.15,	V/0 = = C	irthplace (State or Foreign Country) aryland
	faryland show	o.	Usual Residence of Decedent	nester	10c. City, To	wn or Lo		urloc	k			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the h	Funeral Director	10e. Street and Number 4435 Rolling		ive		10f. Zip Code	643			Citizen of What C	ŕ
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or itema 23a or 28a-f show say follury or other traumatic event, the Medical Exam and must be muffled at an ance.	þ	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ i If Yes, Give Year or Dates:		1	Vas Decedent of H Yes, specify Cub	lispanic Originan, Mexican,	in? (Specify Puerto Rica	Yes or No-	14. Race - Am Black, Wh	nencan Indian,
Maryland 21215-0036	d within 72 ho jiene. r than "natur: the Medical I	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1 2	's Education it grade completed) College (1-4or 5		(Give .	ent's Usual Occup kind of work done DO NOT use retire estic W	during most od)		16b.	Kind of Busines	
/land	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Samuel Brit							rst, Middle, Maid rtude		
	and 2 sho salth and h n 27 is ma er trauma		19a. Informant's Name/Relations Timothy M. J	nip (Type, Print) ohnson/Spo	use	435	g Address <i>(Street</i> Rollin	ng Acr				Zip Code) 21643
Baltimore,	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition 1		20b. Place cemet Dorch	of Dispo: ery, cren 1 e s t	sition (Name of natory or other place) er Mem.	Pk . 2/	Date 24/2		Location - City o	
Balt	permit. Departitimport. sny inj		21. Signature of Funeral Service	Licensee Licensee Licensee	Coale		Name and Addre		Tian	ptom Feet,Fe	uneral derals	Home, PA burg,MD2163
68760,	Physician and was the principle of the p	edical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ORGA Due to (or as b. IN TE Due to (or as c. RHE	a consequence	NG e of): T J A e of):	PNEU PNEU LLUN DAR	MONI	DISE			Approximate Interval Between Onset and Death
O. Box	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	/			23d. Date of d Month	elivery Day Y <i>e</i> ar
Ф	w requires that been signed b should be deta	by	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the ur	nderlying cause gn	ren in Part I.				to the cause of death? Probably 4 □Unknown
of Vital Records,	The ate h	Completed							_	24a. Was an autopsy performed 1 Yes 2	prior to death?	
Division of Vit	anding Physiath. or: After this	ertification; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pendin investig 2 Accident 3 Suicide 6 Could determ	not be 28e. Place of Inj	y Year) 28b	. Time of Injury	28c. Injui	er: 4 ☐ Nurs	sing Home 28d.	heck only one) 5 Residence Describe how in Location (Street City or Town, St.	jury occurred and Number or I	ecify) Rural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical Ce	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the best Examiner: On the basis o and manner st	f examination a	ge, death and/or inv	n occurred at the treestigation, in my o	me, date and opinion, death	place, and occurred a	due to the cause	(s) and manner a	as stated. ue to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifie			D.	29c. Licens	1860	94		Date signed (Mor	nth, Day, Year)
	Sta	ite_	30. Name and address of person KERN K 31. Date filed (Month, Day, Year)	ISSELL	death (Item 23a 2 ar's Signature) (Type,	Print) SOUTH G	REEN	ES	T. BAL	TIMORE	MD 21201
	Regist		FEB 2 3	2005	in St		2026				·	-

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23 2005 ebruaru GERTRUDE ELIZABETH JONES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Heromico 54/11/4/1 Medicol KRAIONA PENINSULA If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕅 F PA Director 220-26-1498 80 March 16, 1924 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28e-f show 1 ☐ Yes 2 ☑ No Maryland Wicomico Salisbury Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1718 Wilson Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. th and Mental Hygiene. 27 is marked other than "natural", or Item traumatic event, the Medical Examination 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3XXWidowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 7th Domestic laborer 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I 2 ALEXANDER HEN SON ELIZABETH CRAIG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 218 Story Road - Aston, PA 19014 27 Helen Pryor/daughter Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. James Church Cem. 03/05/2005 Quantico, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL retta Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or cumplications that shock, or heart failure. List only on cause on e death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed igned by the attending physician and be detached for use as the buriat-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Part I. Other significent þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2000 certificate has 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only of Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Repatient 1 Yes 2 ER/Outpatient 3 DOA After this of Certification: To Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No iours efter death. neral Director: Af illed in by the fur investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours e To the Funeral I To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicaf Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. Medicai 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number title of certifi 29b. Signature and 05 -6 Riverside Dr. 31. Date filed (Month, Day, Year) FEB 2 4 32. F State Registrar

JACKSON

IVERSON

		1 - For State Registrar	State of M	Marylan	nd / Depa	artmer <i>rtificat</i>	nt of H	leaith a Death	and M		giene Reg. No.	200	5	07794
Physic /Medi		1. Decedent's Name (First, Middle, La POSE P.H.		RT	Z					2. Date of De Month	Dey 2	0 20	205	3. Time of Death
Exami		4a. Facility Name (If not institution, gir				4b. City,	Town, or	Location	of Death		4c. (County of D	eath	
		Hebrew Home Of (-	ckvil		24 Hrs	Date of Bir		ontgon		
Funeral Director			Sex 7 1.XIM 2.□F	96	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 01/15/	v, Year)	g. Fr	Countr 1g1a	ce (State or Foreign y)
		Usual Residence of Decedent								01/15/	1909	121	igia	.IIQ
nylan how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							100	d. Inside City Limits
8a-1 e	Director	MD Montgome	ry	Sil	ver Sp	_								1 ☐XYes 2 ☐ No
with ti	ā	10e. Street and Number 11621 New Hampshi	** A***			10f. Zip	0904				-	en of What		•
permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any july go to other traumatic event, if a Medical Examination and page.	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	I.S. 13.			ispanic Ori	igin? (Spe	cify Yes or No		ed St		
of iter of	F	1 ☐ Never Married 2 Married	Armed Force	s?		If Yes, spe	cify Cuba	ın, Mexicar	n, Puerto F	Rican, etc.)	ļ	Black, W	/hite, et	C.
ours al	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes	2X No	Specify:				Specify: V	Vhit	е
72 h	Completed	15. Decedent's E (Specify only highest gi			(Give	dent's Usu	ork done	during mos	at of working	ng	16b. Kir	d of Busine	ss/indu	stry
within	dm	Elementary/Secondary (0-12)	College (1-4d	or 5+)		net N		,			Col	dnote		
Hygie Hygie other	CO	17. Father's Name (First, Middle, Las			Cabi	net r	lakel		er's Name	(First, Middle		oinetr Surname)	. <u>y</u>	
id be fill lental H ked ott ic avan	To Be	Abraham Kurtz						Unkı	nown	Unkn	own			
d 2 shouth end N 7 is mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	s (Street	and Numbe	er or Rura	i Route Numb	er, City or	Town, Stat	e, <i>Zip C</i>	Code)
and 2		Anne Kurtz - Wife	<u> </u>		11621	New	Ham	shire		Silve				
A Titler of H	1	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 [☐Removal from Sta		Place of Disponentery, cre				_	ate		cation - City		
Permit. Peges 1 a Department of Hee mportant: If item iny injury or othe		*4 □ Donation 5 □ Other (Spec		Kii	ng Dav					/3005	Fall	s Chu	rch,	, VA
Depar Permit Pepa Pepa Pepa Pepa Pepa Pepa Pepa Pepa		21. Signature of Funeral Service Lice	ensee	0	Ë	2. Name a lines-	nd Addre -Rina	ss of Facili	_{ty} Funer	al Hom	e_			MD 20904
Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or beart failure. List only Immediate-Cause (Final disease or condition resulting in death)	one cause on each	sed the death line. CV	th. Do not en								1	Approximate nterval Between Onset and Death
certificate be executed right of the properties and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consec										
the death certify the attending y the attending Iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1□Live birth 4□Pregnan 9□ Unknowr	1 2 ☐ Feta tat time of c	al death 3	⊒Ectopic p ⊒ Other (sp		,			2	3d. Date of Month		/ Day Year
es that	by	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	underlying (cause giv	en in Part I	l.		tobacco u: Yes 2[e to the	cause of death?
> 0 5	Completed									24a. Was		24b. Were	autops	sy findings available
0 5 0	E									auto perfo	psy ormed? 210 No	death	to com 1? Yes 2	pletion of cause of
ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	e of Death	(Check only				
Physician: this certific ral director,	To	1 ☐ Yes 2 🔀 No	Hospital: 1 Inp.		ER/Outpatie		and the same of	4 200	ursing Hor	ne 5 🗆 Resi	dence 6	Other (S	Specify)	
	ino in	27. Manner of Death 1 ■ Natural 5 □ Pending		njury Day Ye <i>ar)</i>	28b. Time o		28c. Injur Wor			28d. Describe	how injury	occurred		
en or:	Certification	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At h , etc. (Speci		M reet, factor		Yes 2□	-	28f. Location (City or To	Street and wn, State)	i Number o	r Rural i	Route Number,
To the Hospitel or Att within 24 hours after de To the Funeret Direct completely filled in by t	Medical	29a. Certifier 1 X Certifying F (Check only 2 Medical Ext	hysician: To the beariner: On the basi and manner	s of examina	owledge, dea ation and/or in	th occurred	l at the tir n, in my o	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) date and	and manner place, and	r as stal	ted. he cause(s)
To t To t	Σ	29b. Signature and title of certifier	1/11/11	Mare b.				e number				signed (M		
10		DARBARA	KHITZ	NY M	·D	-	U3	543	6		TEB	RUPK	242	10,2005
		30 dame and address of person who	lazing	,61	m 23a) (Type	Print)	205	FRI	, Re	OCKVI	1200	FML	12	20,2005
St	tate	31. Date filed (Month, Day, Year)	nns Reg	istrar's Sign	A A	ast)								

			For State Registrar	State of Ma	iryland / Depa <i>Ce</i>	artment of Heartificate of De	alth and M eath		ene 0 0 5	07795
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		SALIBI		unej			February	16 200	5 7:50 A ^M
	Examin	er	4a. Facility Name (If not institution, giv		.1	4b. City, Town, or Lo	ocation of Death		4c. County of Dea	
	Funeral		Montgomery Gener 5. Social Security Number 6. S		(In yrs. last birthday)	01ney	f Under 24 Hrs.	8. Date of Birth	Montgo	
	Director		090.62.4414	⊠ M 2□F	82 yrs.	Months Days	Hours Min.	Sept. 26	, 1922 Pa	thplace (State or Foreign ountry) Lestine
	pg &		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	anting				
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show any injury or other treumatic event, If a Modical Exaction of the final Legible and other.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	0	_	Specify:	noan, etc.)	Specify: W	
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121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+}	DO NOT use retired)	•		Printing	
d 2	filed Hygie other ant, II	e Co	17. Father's Name (First, Middle, Last,)			B. Mother's Name	(First, Middle, M		
an	td be lental kad c	O B	Issa Khoury				Sophie	Khoury		
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and	d Number or Rural	Route Number,	City or Town, State,	Zip Code)
Σ	and 2 salth a n 27 I		Tony Khoury/Son			Signature	Court,	Rockvil	le, Maryla	and 20853
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<u>~</u>	99 = 50		Nancy A.	Vacent						ng, MD 20904
			23a. Part1. Enter the disease, or com shock, or head failure. List only	plications that caused one cause on each lin-	the death. Do not ent e.	er the mode of dying, s	such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
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90	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):		1			
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	± oos	ian/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				23d. Date of de	liven
Вох	The law requires that the death cer tite has been signed by the attendir bage 2 should be detached for use	iciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		Ectopic pregnancy Other (specify)			Month Month	Day Year
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ord	equir sen si ould		CHE	GASHIOW	2 FAIW	ne c. Di	Hicele	1 🗆 Yes	2 2 No 3 □ P	obably 4 □Unknown
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o	Phys er this eral di	\vdash	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day	t 2 ER/Outpatien	28c. Injury at	4 Nursing Hom	e 5 🗌 Residen 8d. Describe how	ce 6 Other (Spe	cify)
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	itel or A irs after ral Dired lled in by								0.0.0)	
	To the Hospitel or A within 24 hours after To the Funeral Direcompletely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exan	ysicien: To the best of niner: On the basis of and manner stat	examination and/or inv	n occurred at the time, overtigation, in my opinion	date and place, ar on, death occurred	nd due to the cau d at the time, dat	use(s) and manner as e and place, and due	s stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	7		29c. License nu			d. Date signed (Mont	,
)	1			Hecers	, we D	DIA	192		2/16	105
	(30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)	DAAA D	721/2. 1	4) He	sen amout
	Sta	te	31. Date filed (Month, Day, Year)	3. Registra	r's Signature	J + 1 1 0 E-14	artita, Di	- C	~ USATON	10 00 70%
	Registr	ar	31. Date filed (Month, Day, Year) FEB 2 2 200	5 Blew	I Apr	de				105 , up 209ds

State of Maryland / Department of Health and Mental Hygiene [] [5 1 - State Registrat Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Ruth Dorothy Knicely 4281 2005 ebrua (de. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day Year) 11/18/1912 Birthplace (State or Foreign Country) **Funeral** 1 M 2 X 212-05-2999 92 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28e-1 show 10d. Inside City Limits the Medical Exercises hast be notified at Director MD Washington Hagerstown 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 21740 10g. Citizen of What Country? 11 W. Baltimore Street, Apt. 110 US filed within 72 hours after death thygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. importent: If Item 27 is marked other than "na any injury or other traumatic event, Ite Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Horiato Palmer Lora Ella Gorsuch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E. Artz / Daughter 12404 Walnut Point West, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 02/26/2005 | Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licens, e 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Qnset and Death Immediate Cause (Final disease or condition resulting in death) Myocardid Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Dunknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 2 100 1 Yes 2 No 1 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient P 12 Inpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death filled in by the 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14001 2-22-2005 D21457 Name and address of person who completed cause of death (Item 23a) (Type, Print) ABOUL WATERD, MD _ 12821 - OAKHILL AVIZ. HAGERSTOWN MD 21742 31. Date filed (Month, Day, Year)
FEB 2 5 32. Registrar's Signature State Registrar

05-01241 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland.		artment of H		nd Mental	Hygiene	000=	07707
	0.	9.	Decedent's Name (First, Middle, L.)	ast)				-	2. Date	of Death		3. Time of Death
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	/Medio		4a. Facility Name (If not institution, gi	and the same of th	r)		4b. City, Town, or	Location of			County of Death	1. OIF
			11330 CHERRY HILL	ROAD			BELTSVII	JE		PF	RINCE GEO	RGES
	Funeral			Sex 7. A	Age (In yrs. last		If Under 1 Year Months Days	If Under 2			9. Birthi	place (State or Foreign
	Director		058-46-6480	1⊠M 2□F	_53	Yrs.				17,19		nican Republic
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
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	r 28a	rec	Maryland Prince 10e. Street and Number	George's	Be	1tsvi	10f. Zip Code			10g. Ci	itizen of What Cou	ntry?
	h with	ai D	11330 Cherry Hil	1 Road #20)3		20704				USA	
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36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Madiesi Examinar musi be notified at	y Fu	1 Never Married 2⊠ Married	1 ☐ Yes 2 ☐ If Yes, Give	No				Dominica		Specify: Whi	
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g	al Hyg othe	3e C	17. Father's Name (First, Middle, Las	t)				18. Mother	s Name (First, M.			
Maryland	Ments Ments arked	To	Juan Pablo Liria	no				Isab	el Nunez	Z		
ar	2 sho		19a. Informant's Name/Relationship	(Type, Print)			g Address (Street a					
<u>6</u>	l and lealth im 27 her ti		Candida Liriano	Wii			Shiholt	Court				
و	it of F		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3		• Gate	otoni cron	sition <i>(Name of</i> natory or other plac eaven	θ)	Date		ocation - City or To	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event; the Medical Examinat must be notified at once.		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Fune al Service Lice				Cemetery	F			er Sprin	, MD
Ba	Depa Impo any i		Alolast ()	1 1 :		Fra	Name and Addres	Collin	s Funera	11 Hom	e, Inc.	1m 00001
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	ti cian: Th certificate rector, pag		or Western Grand and Grand						12 Y	es 2 No		2 No
₹	Physician: r this certifica ral director, i	o Be	25. Was case referred to medical examiner? 1∑ Yes 2 □ No	Hospital:		/Outpatien	Othe		f Death (Check o		. Wou to	CCEME
Division of Vital	ding Physician: The h. A. After this certificate hit funeral director, page		27. Manner of Death	28a. Date of In	jury 28	b. Time of	28c. Injury Work	4 114013		ribe how inju	6 AOther (Specification occurred)	// POEME
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N S	l or Atten after deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	289. Place of I	njury - At home etc. (Specify)	, farm, stre	eet, factory, office			on (Street ar r Town, State	nd Number or Rura	I Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai	29a. Certifier 1 Certifying P (Check only one) Medical Exa	hysician: To the bes miner: On the basis and manners	of examination	dge, death and/or inv	occurred at the time restigation, in my op	e, date and pinion, death	place, and due to occurred at the t	the cause(s ime, date and) and ma <i>n</i> ner as st d place, and due to	ated. the cause(s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier		^ -		29c. License	number		29d. Da	te signed (Month,	Day, Year)
}	/		Matn.	· · ·	1200	1 -	0	CME		FEBR	UARY 17,	2005
	5		30. Name and address of person who	completed cause of	death (Item 23	(Type, I	Print) 111 D	lon- C	Troct D			
				1ch - 1011.	AK M	D		GIII 21	reer B	3T LTII10	re, mary.	land 21201
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			For State Registrar	State of Maryla		artment of H			giene	5 07798
			Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Douglas Fenwick I	yons				FEBRUA		^{Year} 005 3:50a [™]
	Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or	Location of Deat		4c. County o	
			695 AMERICANA DRI	VE # 13		ANNAPOL	IS		ANNE A	RUNDEL
	Funeral		1		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	r, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	¹X M 2 F 80	Yrs.			Dec. 13	2, 1924	Maryland
	land bw		10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	ō	Maryland Anne An	undel		Δ	nnapolis			1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	direct		10f. Zip Code	шаротть		10g. Citizen of Wh	hat Country?
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98	or Ita	F	1 ☐ Never Married 2 Married	1 X Yes 2 □ No W If Yes, Give	MIT	1 ☐ Yes 2 🛣 No	Specify:	to rican, etc.)	Specify:	, White, etc. White
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0	Hygi other ant, 1		17. Father's Name (First, Middle, Las.			Lawyer	• •	ne (First, Middle,	Sel I-I Maiden Sumame	Employed
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ary	shound M	-	19a. Informant's Name/Relationship	, ,	19b. Maili	ng Address (Street a				Itate, Zip Code)
Σ	and 2 alth a 27 ls		Florence P. Lyons	/ Spouse	695	Americana	Drive A	pt. #13	Annapoli	is, MD 21401
altimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23e or 28e-f show any injury or other traumatic event, the Mudical Exeminer must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [. Place of Dispo	sition (Name of matory or other plac	e)	Date	20c. Location - C	City or Town, State
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alt	permit. Departr Importe any inju		21. Signature of Funeral Service Lice							neral Home, Inc.
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o.	that the death certified by the attending I detached for use as	Physician/Me	9 Unknown	9□Unknown						
ري ح	law requires that the death certifi as been signed by the attending 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
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	The ate h page	Completed						perfori	med? del	or to completion of cause of ath? Yes 2 \(\subseteq \text{No} \)
Vital	Physician: Th this certificate ral director, paç	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or		
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Division	l or Atten after deat Director: I in by the	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		City or Town		AMEVICANA Dr.
	spital		29a. Certifier 1 ☐ Certifying Pl	nysician: To the best of my k			o data and place	#13,	minapall	SIMD
	8 Hos 24 h e Fur letely	edical		niner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my op	pinion, death occu	rred at the time, d	ate and place, an	d due to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed ((Month, Day, Year)
)			· Canal H	Allan m	d	OC	ME		FEBRUARY	15, 2005
			30. Name and address of person who	completed cause of death (It	em 2 3a) (Type,	Print) 111 5	~·			1 1 0 0 0 0 0
			CAROL H1	tuAN m	el	III Pe	nn Stree	t Balti	more, Ma	aryland 21201
	Sta		31. Date filed (Month, Day, Year) FEB 1 8	32. Rigistrar's Sig	nature	Corelle)				
	Registr	ar	LED TO	LUUJ PURCO	100	CARL				1

Please Type	e or Print in	Black Indelible Ink.	Ensure All Copies	Are Legible
_				

			1 - For State Registrar	State of i	Maryland / De C	pariment of H e rtificate of L		itai Hygiei Reg.	6000	0//99
	Physici	an	1. Decedent's Name (First, Middle Ellen						Day Year	
1	/Medic		4a. Facility Name (If not institution		er)	4b. City, Town, or		ebruary	4c. County of De	
	Examin	er	Doctors Commu			1	rham		Prince G	
	Funeral		5. Social Security Number		Age (In yrs. last birthda	y) If Under 1 Year		Date of Birth (Month, Day, Ye		rthplace (State or Foreign
	Director		577-88-8917	1 M 2 200F	91 Yrs.	Months Days		/3/13		sh., D.C.
	fand ow		Usual Residence of Decedent 10a, State 10b, County	y	10c. City, Town or	Location				10d. Inside City Limits
	a-f sh	tor	Md. Princ	e George's	Fo	irmount He	eights			1y Yes 2 □ No
	th with the 23s or 28	Funeral Director	10e. Street and Number 1105 60th Ave	пие		10f. Zip Code 207	743	10g.	Citizen of What C	Country?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show important: if item 27 is marked other than "natural", or items 23s or 28s-f show all high round to other traumatic event, the Medical Examinal be notified at ance.		11. Marital Status 1 □ Never Married 2 □ Mar 3 ⊋Widowed 4 □ Divorce	If Yes Give	ZINo	3. Was Decedent of Hi If Yes, specify Cubar 1 Yes 280 No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - Am Black, Wh Specify:	
15-0	"natu	Completed by		nt's Education est grade completed)	16a. Der (Gi	cedent's Usual Occupa ve kind of work done d . DO NOT use retired;	ation luring most of working	16b	. Kind of Busines	s/Industry
12.	withir iene. then	dmo	Elementary/Secondary (0-12) 12th	College (1-4	or 5+)	. bo nor asa ratiraa, ssionary	,	C	hurch/Co	mmun itu
	Hygi other	Be C	17. Father's Name (First, Middle	, Last)	114		18. Mother's Name (Fit			инанху
/lar	ould be Mental Marked o	To B	Henry Washing	ton			Blanche G	rayson		
Maryland	alth and Menialth and Menialth and Menialth and Indianake		19a. Informant's Name/Relation. Blanche M. Sim			-	and Number or Rural Ro Ave., Lando		-	Zip Code)
3altimore,	permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr once.		20a. Method of Disposition 1		cemetery, c	position (Name of rematory or other place Mem. Park	Date 2/26/05		Location - City o	
Balt	permit, Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee W. Pro	it	22. Name and Addres H. S. Washir	s of Facility ngton & Son oughs Ave.,,	s Co. , Ir	ic.	.D.C. 20019
			23a. Part1. Enter the disease, or shock, or heart failure. Lis	r complications that caust only one cause on each	sed the death. Do not e	inter the mode of dying	g, such as cardiac or res	spiratory arrest.	suxuycou,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	- ArTer	rioscievat	or Caudion	Ascular Di	state		Onset and Death 9 Lans
	/Medical Examiner									
		Jer	Sequentially list conditions if any, leading to immediate	b. Due to (or	as a consequence of):					
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.						
60,	be exe	ai Ex	resulting in death) Last	Due to (or	as a consequence of):					
68760,	tificate ig physi as the	ledicai		d						
.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		n 2 ☐ Fetal death 3 t at time of death 5	B Ectopic pregnancy i Other (specify)			23d. Date of de Month	elivery Day Year
Δ.	is that pred bi		Part II. Other significant condition					23e. Did tobacc	o use contribute (o the cause of death?
Records,	w require been sig should b	Completed by	Respiratory	failure Ve	ntilutur A	eprad eni	7	1 Tes	2 → No 3 □ F	robably 4 Unknown
ecc	e taw r has be je 2 sh	nple	Jeptic Shack					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
al H			gastrointists.		bleeding			performed 1 Yes 2 1		s 2 No
Vital	Physicien: this certificated rail director, i	Be	25. Was case referred to medica examiner?	Hamilah d		Othe	26. Place of Death (Ch			
of	Phys or this oral di	.: To	1 Yes 2 No 27. Manner of Death	1 ∐ Inpa 28a. Date of li (Month,	atient 2 ER/Outpati	of 28c. Injury	4 Nursing Home at 28d.	5 Residence Describe how in		ecify)
ion	Attending Ir death. sctor: After by the funer	atior	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, i igation	Day Year) Injury	Work	? ′es 2 □No			
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office	28f. I	Location (Street City or Town, St	and Number or F	lural Route Number,
	itel o rrs aft rel Di lled in	Cer								
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 ☐ Certifyi (Check only 2 ☐ Medical one)	ng Physician: To the be Examiner: On the basis and manner	s of examination and/or	ath occurred at the time investigation, in my op	e, date and place, and d inion, death occurred at	due to the cause t the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comp	×	29b. Signature and title of certific	1 /	. 0	29c. License		1	Date signed (Mon	
•			Bull	nellor	2 Cm	00	1852	F	brushy	20,2005
R	-(2)				of death (Item 23a) (Typ 203 QUEEn	e, Print) USBURY RU	1 H44173	ville 1	10 207	20,2005
	Sta Registr	- 1	31. Date filed (Month, Day, Year) FEB 2-3) 32 Regi	istrar's Signature	1				

	1	State of Maryland / Dep			ene2005	07800
Physicial /Medica Examine	1 -	1. Decedent's Name (First, Middle, Last) William Richardson Logan 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month February	Day Year 21 2005 4c. County of Deat	3. Time of Death 11:30 A ^M
Funeral Director			Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y. October	Anne Ari 9. Biri 28, 1914	undel hplace (State or Foreign unity) MD
US after death vir. or Itams 23e	by Funeral Director	1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates:	10f. Zip Code 21401 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	. Citizen of What Co J. S. A. 14. Race - Ame Black, White Specify: Wh. b. Kind of Business/	ncan Indian, a, etc.
E dalp	lo Be Completed	Elementary/Secondary (0-12) College (1-40r 5+)		in g	Telephone iden Sumame)	
or Heal		19a. Informant's Name/Relationship (Type, Print) 19b. Mail Patricia A. Logan/daughter 2020	vineyard Road, Anno sition (Name of matery or other place)	al Route Number, C Capolis, M Date 20	Eity or Town, State, 2 MD 21401 c. Location - City or	Town, State
Baltimore, permit. Pages 1 at Department of Hes important: if them any injury or othe		21. Signeture of Funeral Service Licensee Luchard 21. Signeture of Funeral Service Licensee 1	2. Name and Address of Facility R.T 11 S. Queen Street	. Foard F , Rising	Calvert, uneral Ho Sun, Mari	ome, P.A.
E E	ai Examiner	23a. Parf. Enter the disease, or complications that caused the death. Do not ensirely considered and the death. Do not ensirely cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that infriated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardiac o	or respiratory arrest		Approximate Interval Between Onset and Down
BOX 68 ath certifical ttending ph	Physician/medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
	Completed by Pri	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes 24a. Was an	24b. Were au	obably 4 Unknown
hysician: this certifical	10 De	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	nt 3 DOA Other: 4 Nursing Ho	autopsy performer 1 Yes 2 • h (Check only one) me 5 Residence	d? death? 1 Yes	
DIVISION Of VITA or Attanding Physician: after death. Director: After this certification in by the funeral director.	Certification:	27. Manne of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident 3 Suicide 4 Homicide 288. Date of Injury (Month, Day Year) 288. Date of Injury 28b. Time Injury 288. Place of Injury - At home, farm, so building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stree City or Town, S	et and Number or Ru	iral Route Number,
he Hospita in 24 hours he Funeral pletely filled	edical	29a. Certifler (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occurr	ed at the time, date	se(s) and manner as and place, and due	to the cause(s)
2		39 Name and address of person who completed cause of death (Item 23a) (Type	10 Pal A212 /3		2-21-	2005
State Registra	r	31. Date filed (Month, Day, Year) FEB 2.3 2005 32. Registrar's Signature	7			

			1 - For State Registrar	State of	Maryland	/ Depa	artment <i>rtificate</i>	of He	ealth a Death	ind M		giene Reg. No.	005	5 (780) [
	Physici	an	Decedent's Name (First, Middle, in the control of the control	ast)							2. Date of De. Month	ath Day	,	/ear	3. Time of D	Death	
	/Media	al	Delores 4a. Facility Name (If not institution, g	in street and num	Lep	ley	4b. City, To			(D - oth	02 -	26	- 0	5	8:42	AM	
	Examin	er	213 Oak Street	ive street and num	1001)		Cumb			r Death			County of egan				
	Funeral		Social Security Number 6		7. Age (In yrs. las	t birthday)	If Under 1		If Under 2	24 Hrs. Min.	8. Date of Birt	lle.		9. Birthola	ace (State or	Foreign	
	Director		214-28-6335 Usual Residence of Decedent	1□M 2♥F	71	Yrs.	onus	Juys	110013		Nov 4,	1933	3	MD	· y)		
	yland IOW		10a. State 10b. County		10c. City, 1	Town or Lo	ocation							10	d. Inside City	Limits	
	Mar-1st	ctor	MD Allega	iny	(Cumb	erland								1 X Yes	2 No	
	or 28	Dire	10e. Street and Number				10f. Zip C					10g. Citiz	zen of Wh		ry?		
	eath v	eral	213 Oak Street	12 Mas Door	dent Ever in U.S.	10	Was Donate		1502	1-0 (0	7 7		USA				
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. The Mudicul Examinating the multiped at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	ces? 2 No	1	was Deceder If Yes, specify		Specify:	in? (Spec , Puerto P	cify Yes or No- lican, etc.)		4. Race - Black, Specify:	White, et	tc.		
200	72 hou	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual	Occupat	tion	afadiia			nd of Busi				
2	Aithin ne.	mple	Elementary/Secondary (0-12)	College (1-		life.	kind of work DO NOT use	retired)	<i>iri</i> ng most	or workin		_					
2	Fled w Hygie ther th		12. 17. Father's Name (First, Middle, La	st)	H	omer	naker		19 Mothor	r'a Nama	(First, Middle,		Hom				
Maryland 21215-0036	nould be if Mental narkad o	To Be	William B. Norr	is					Emr	na M	ae Noi	rris					
a S	d 2 sh th and th and 27 ls n traun		19a. Informant's Name/Relationship Jerry Lepley	(Type, Print)		19b. Mailir	ng Address (S)0 Old	Street ar Wille	nd Number Owbra	ror <i>R</i> umal OOK	Route Number	er, City or erlar	Town, St.		D 215	02	
	s 1 an f Heal ftem 2		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name	of		Da			ation - Ci				
Ĕ	Page nent o		1 XBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		naner I		natory or other emetery		' i	3,	/1/2005	Cur	nberl	and	M	1D	
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service Lig	ensee	1 1 1 1	22	Name and Scar	Address Delli	of Facility Funera	al Hor	ne, P.A.						
	0 0 E € 0		Xum	100	W		108	Virgir	nia Ave	enue:	Cumberl	land, l	MD 21				
H			23a. 24n1. Fiter the disease, or co shock, if heart failure. List on Immediate Cause (Final	ly one cause on ea	ich line.			ot dying,	, such as o	ardiac or	respiratory ar	rest,		1	nterval Betwe		
	Physician /Medical		disease or condition resulting in death)	a. Due to (c	LUN or as a consequer		ANCER						Approximate Interval Between Onset and Death UNK				
ľ	Examiner		Sequentially list conditions	b		.00 0.7.											
7	sit s	iner	Sequentially list conditions, cause. Enter Underlying	Due to (:	и ав в сопвесиог	nda or):											
_	ficate be executed physician and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	or as a consequer	nce of):	_							_			
8760,	le be e ysiciar e buri	dicai		d.													
9	rtifical ng phy	Medi	IF FEMALE:														
Вох	at the death certific I by the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	ome of pregnancy th 2 Petal de	ath 3	Ectopic preg					2	3d. Date o		v Day Ye		
0	0 0 9	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐Unkno	int at time of deat wn	h 5□	Other (spec	ify)					IVIOITI		ay 10	ai	
٥.	The law requires that the ste has been signed by the bage 2 should be detached.	by Ph	Part II. Other significant conditions	contributing to dea	ath but not resulting	ng in the u	nderlying cau	se giver	in Part I.		23e. Did to	bacco us	e contribu	ute to the	cause of dea	ath?	
ğ	w require been sig should b	ted t									1 🗆 Y	es 2□	No 31	Probab	oly 4 🕅 Un	known	
Records,	e law r has be je 2 sh	Completed									24a. Was a		24b. We	re autops	sy findings av	ailable	
											perfor	méd? 2□ X o	dea 1 🗔	th? Yes 2	□ No		
Vita		o Be	25. Was case referred to medical examiner? 1 Tyes 2 XNo	Hospital:				Other			Check only or						
ō	ding Phys h. After this funeral di	P 4	27. Manner of Death	28a. Date of	Injury 28	Outpatien b. Time of		Injury a	at Nui:	-	e 5X Resid						
S		atio	1 Natural 5 Pending 2 Accident investigat	on	, Day Year)	Injury	М	Work? 1 ☐ Ye	s 2 🗆 N	lo							
Division of	l or Att after de Direct	Certification:	3 Suicide 6 Could not determine	d 28e. Place	of Injury - At home g, etc. <i>(Specify)</i>	, farm, str	eet, factory, c	ffice		28	3f. Location (S City or Tow	treet and n, State)	Number	or Rural F	Route Numbe)r,	
_	Hospital or Attend 14 hours after death Funeral Director: tely filled in by the	al Ce	29a. Certifier 1 XCertifying 8	Physician: To the b	nest of my knowle	dae desti	Occurred at	the time	date and	place an	nd due to the	Mues/-1	and more	0.00			
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Ex-	aminer: On the bas and manne	sis of examination	and/or inv	estigation, in	my opir	nion, death	occurred	at the time, o	iate and p	place, and	due to th	he cause(s)		
	To the To the complete	M	29b. Signature and title of certifier	and.			29c. L	icense i	number		2	29d. Date	signed (A	Month, Da	ay, Year)		
			Magkin				I	6	04-	18		03	01	05			
	6		30. Name and address of person wh	completed cause									, ,	•			
	* Sta	te	31. Date filed (Month), Day, Year,	D. 32. Rg	gistrar's Signature	§25 K	ent Av	enu	e Cur	nber	land MI	21	502				
	Registr		MAR 08	2005	, y		A ME										

				State of Ma	aryland / Depa	ertment of Health and M	•	
				1 - State Registrar (D)	Cer	tificate of Death	Reg. N	
		Physici	an	Decedent's Name (First, Middle, Last)			_ Month E	2005 Year 0849 M
		/Medic Examin		MILTON PEARCE MERRYMAN 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		tc. County of Death
	1	Exami	le1	The Memorral Huse	,tal	Easton		Talbot
		Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea SEPT. 3,	9. Birthplace (State or Foreign Country)
		Director		212-01-0699 10 M 2□F Usual Residence of Decedent	88 Yrs.		SEPT. 3,	1916 MARYLAND
		nylan how	_	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
~		be tiled within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or tleme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Director	MARYLAND TALBOT	EASTO		1	1 V Yes 2 No
1 may		with the		10e. Street and Number		10f. Zip Code		Citizen of What Country?
3		ne 23	by Funeral	700 PORT STREET 11. Marital Status 12. Was Decedent	Ever in U.S. 13. V	21601 Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
>	က်	or Iter	F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 If Yes, Give	No		Rican, etc.)	Black, White, etc.
7	03	ours a	d by	3X Widowed 4 □ Divorced Year or Dates:		Yes 2 No Specify:		SpecifyWHITE
2	21215-0036	within 72 hours after ene. than "natural", or Ite the Medical Examina	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry
6	12	withir ene. than than	mp	Elementary/Secondary (0-12) College (1-4or 5	5+) ENGII			EFENSE
0		filed Hygi other		17. Father's Name (First, Middle, Last)	ENGTI		e (First, Middle, Maid	en Surname)
(7	<u>la</u> n	lid be fental rked ric ev	To Be	EDWARD CLINTON MERRYMAN		LYDIA	PEARCE	
0	ary	should be filed within and Mental Hygiene. Is marked other than aumalic event, Ine M	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Run	al Route Number, City	or Town, State, Zip Code)
ton	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. ODGE.		STEPHANIE L. HAY /DAUGHTER	126 Q	JIET WATERS PLACE		S, MD 21403
1	ore	ges 1 it of He if iter or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place)		Location - City or Town, State
E	Ë	nit. Pag partment cortant: injury d		4 □ Donation 5 □ Other (Specify)			2-2005	STER, MARYLAND
	Baj	Depari Depar Impor any ir		21. Signature of Funeral Fervice Licensee	(5 P Å	ELLOWS, HELFENBEI	AND NEWN	AM FUNERAL HOME, P.A
				23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do not entr	IO S. HARRISON STI	REFT FAST	ON, MD 21601 Approximate
		Discontinue			hospic o	1	1	Interval Between Onset and Death
	7	Physician /Medical		resulting in death)	a consequence of):	1021 Another Di	y monay	disease years
		Examiner					\bigcirc	
		D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	a consequence of):			
		acute and trans	Examiner	that initiated events				
	760,	be executed sician and burial-transit		Due to (or as	a consequence of):			
	687	9 8 9	dlcal	d				
1		certifica nding physise as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant			-	23d. Date of delivery
2	Box	death le atter	Iclar	in the past 12 months?		Ectopic pregnancy Other (specify)		Month Day Year
12	0	w equires that the d b en signec by the should be detached	hys	9 ☐ Unknown				- June
Y	S, F	equires that the en signec by th ould be detache	by P	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause given in Part I.		o use contribute to the cause of death?
2	Records,	equir en si ould	ted	Correction of curtains of	13248		1 🗆 Yes	2 a No 3 Probably 4 Unknown
)	ec	a se	ompleted	confestive heart	tailme		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			Co	7			performed? 1 ☐ Yes 2	death?
	Division of Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?		Other	(Check only one)	
	o	유 는 E	: To	27. Manner of Death 28a. Date of Inju	iry 28b. Time of	28c. Injury at	me 5 Residence 28d. Describe how in	6 ☐Other (Specify) jury occurred
	ion	nding I tth. :: After e funer	atlor	1 ∰Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y Ye <i>ar)</i> Injury	Work? M 1 ☐ Yes 2 ☐ No		
	Vis	Atternation of the part of the	Certification:	3 Suicide 6 Could not be 28e. Place of Inj	jury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
		talor rs afte al Dir	Cert	Tioning, et	c. (Specify)		0.0, 0. 70	
		To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Chack only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st.	if examination and/or inv			
		To the To the sample	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
				Javel / ()low w	7	139749	2/	121/05
				30. Name and address of lerson who compteted cause of c			- /	1
				DAVID G. OLIVER M.D. 503		LANE, EASTON, MD	21601	
	1	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 2 2005	rar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 07803 Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 9 Bey Month Feb **Physician** 2005 5:40 A Theodore Cahall Manship /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Caroline Denton Ruxton Health If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. 8. Date of Birth
(Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Funeral 1⊠M 2□F Yrs. Sept 18 1917 Delaware 216-18-2016 Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Marylend nant of Health end Mentel Hygiene. 10c. City, Town or Locetion 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director Caroline Ridgely or 28a-1 Maryland| 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number PO Box 222 21660 USA or items 23s 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify Specify: Be Completed by 3 M Widowed 4 ☐ Divorced White Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) end Mentel Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland truck driver 08 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Lucy Jane Porter Manship Theodore Manship 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health Important: If Item 27 Irvin P. Manship/ son 1353 Market Street Denton, Maryland 21629 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ò 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ridgely Cemetery Feb 22 05 Ridgely, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licensee Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cerebrovascular Accident Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner or Attanding Physician: The lew requiras that the dasth certificate ba executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? erebral meningiona 1 ☐ Yes 2 No 3 Probably 4 Unknown To the Hospital or Attanding Physician: The lew requires the within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, pega 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Y36 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 27. Menner of Death 1 Death 2 Accident 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier െ rtifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number
D35284 29d. Date signed (Month, Day, Year)
2/19/05 29b. Signeture and title of G. Cuashington St Eastm M0460 30. Name end address of person who completed cause of death (Item 23e) (Type Accen mo 32. Registrer's Signeture State

Registrar

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FEB 2 2 2005

			For State Registrar	State of Mary	land / Depa		Health and		•	07804
	Dharini		1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physici /Medio		Marilla Jane Mc	Carthy				Februar	y 1 9, 2ŎŨ5	1:45 p м
	Examir		4a. Facility Name (If not institution, give	street and number)			or Location of De	ath	4c. County of Death	
			201 Federal Stre			East			Tall	
	Funeral Director		000-20-2971	TH OFF	yrs. last birthday) 76 Yrs.	If Under 1 Yea Months Day		in. May 26,	1928 II	nplace (State or Foreign Intry) LINOIS
\circ	land		Usuel Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
3	the Maryl	Director	Maryland Tal	bot	Eas	ton			0-011	1 Mes 2 □ No
2	with	늅		Apt 70		Tot. Zip Code	21601	'	0g. Citizen of What Co	
_	nus 23	eral	201 Federal Street	12. Was Decedent Ever	in U.S. 13	Was Decedent of		(Specify Yes or No-	14. Race - Amer	
36	n 72 hours after death with the Maryland "natural", or Itams 23a or 28e-f show edical Examination notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Moivorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i	If Yes, specify Cu 1 ☐ Yes 2 ☐ N	/	(Specify Yes or No- erto Rican, etc.)	Black, White	
Maryland 21215-0036		Completed	15. Decedent's Edi (Specify only highest grad	le completed)	16a. Dece (Give life.	dent's Usual Occ kind of work don DO NOT use reti	upation e during most of v red)	working	16b. Kind of Business/I	
212	d within giene. ir than "	E	Elementary/Secondary (0-12) 12	College (1-4or 5+) 4	Medic	al Sales	Represe	entative	Healt	ch Care
פ	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)					lame (First, Middle, M	Maiden Sumame)	
<u>lar</u>		ToE	Benjamin Earle R	oberts			Han	riet Jane	Whittle	
Mary	s 1 and 2 should f Health and Men itam 27 is marks other traumatic		19a. Informant's Name/Relationship (7) Cynthia Giles/Daug			-			City or Town, State, Zington, R.	
e,	itam itam othe		20a. Method of Disposition		Db. Place of Dispo	sition (Name of natory or other p	lace)	Date	20c. Location - City or 1	own, State
Ë	Pages nent of ant: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State M			·	2/21/2005	Cambridge,	Maryland
Baltimore,	permit, Pag Department Important: f any injury o once.		21. Signature of Funeral Service Licens	eu-Remu	vell 2	Name and Add id Shore 272 Huds	ress of Facility Cremati son Rd	ion Center Cambridge	, P.O. Box , MD 21613	
			23a. Part T. Enter the disease or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	death. Do not ent	er the mode of d	ying, such as card	liac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Cara (Cara a cor	ac ar	rest				
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. assured Due to (or as a cor	rich Ca	adion u	uggst	hy		6-months
,092	te be executed ysician and ne burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	nsequence of):					
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy agge 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown'	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnar Other (specify)			23d. Date of delin Month	very Day Year
ds, P	uires that signed b d be deta	þ	Part II. Dther significant conditions co	1				23e. Did tob	pacco use contribute to	the cause of death?
Vital Records,	aw require s been si	Completed	Chronic &	In object	ue lo	w kens	ia -	24a. Was ar		opsy findings available
Re	The lav	omi		3,400		2000/00		- autops perform 1 ☐ Yes 2	y prior to co ned? death? 2.D√No 1. ☐ Yes	ompletion of cause of 28 No
ita	ician: T certificat ector, pa	Bec	25. Was case referred to medical examiner?				26. Place of D	Death (Check only on	X	
of V	dii d	To	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3□ DOA	other: 4 Nursing	g Home 5 Reside	nce 6 Other (Spec	ify)
ion o	ding After fune		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	f 28c. Inj		28d. Describe ho		
Division	al or Attended s after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp		eet, factory, offic	8	28f. Location (Sti City or Town	reet and Number or Rui i, State)	al Route Number,
	To tha Hospital or Atte within 24 hours after de To tha Funaral Directo completely filled in by th	ledical (29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exa- and manner stated.	knowledge, deat	n occurred at the vestigation, in my	time, date and pla opinion, death or	ace, and due to the ca ccurred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier			29c. Lice	nse number		d. Date signed (Month)	
)			MBBun	12		D	43040)	2/21/0:	5
			30. Name and address of person who c	ompleted cause of death			1 0		2/21/0:	
			Mira B Burge 31. Date filed (Month), Day, Year)	signe 5	10 Joll	ewill A	tre En	ston MC) 21601	
	Sta Registi		31. Date filed (Montal, Day, Year) FEB 2 2 2	32. Agistrar's S	ignature /	sele		,		

			1 10050		/Describe ink			_	
٨	-4		For State Ragistrar	State of Maryland	Certificate of		vientai Hygiei Reg.	2005	07805
	hysicia /Medic		1. Decedent's Name (First, Middle, La	Luther	Mack	<	2. Date of Death	Day Yeer	3. Time of Death 5 2 / 1/3 M
	xamin		4a. Facility Name (If not institution, giv	a street and number)	4b. City, Town, o	r Location of Death		4c/County of Dea	ith /
E	neral		5. Social Security Number 6. S		o, fa/ Can st birthday) If Under 1 Year	1 b R i dq If Under 24 Hrs.	8. Date of Birth	DORCH 9. Bir	thplece (State or Foreign ountry)
	ector		XX0-10-6616	MM 20F 83	Yrs. Months Days	Hours Min.	(Month, Day, Ye)	1 7 7 1	nary land
/land	1		Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	fillied	ctor		hester C	ambridg	e			1 Yes 2 No
II Z I Z I 3-0030 Iiled within 72 hours after death with the Maryland Hygiene, Hygiene, Hygiene, 23a or 28a (ahruu	1 De C	Funeral Director	701-Race St	peat Apt 5	10f. Zip Coted	11.13	10g.	Citizen of What Co	ountry?
r death	er mus	ınera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of H	dispanic Origin? (Span, Mexican, Puerto	Decify Yes or No-	14. Race - Ame Black, Whit	
rs afte	ricarulu Transitu	by Fu	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:	,	Sanaihu A	ack
72 hou	dical E	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of work	king 16b	. Kind of Business	
within ene.	Ne Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		4	orker Se	an Cand	Tinduction
VICE IN A INTERPRETATION OF THE PROPERTY OF TH	vent,	Be Co	17. Father's Name (First, Middle, Last		100001107	18. Mother's Nam	e (First, Middle, Maid	ten Surname)	211903119
should to	natic e	2	UNKNOWY 19a. Informant's Name/Relationship		19b. Mailing Address (Street		May Ma		7:- Codel
nd 2 st alth and	iten zz le markeu otres then heures, or teme zoa or zea-renow other traumatic event, the Mudical Examinar must be mailited at		Diane Fo	rrare	1005 Jims	and Number of Hull	111-1	dae. M	D. 21613
n o -	or othe	Ì	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	ce of Disposition (Name of netery, crematory or other plan			. Lecation - City or	Town, State
	injury	}	*4 □Donation 5 □Other (Special Signature of Funeral Service Lice	y) Bet		S of Facility	,	Mbridg	e, Maryland
Dermit. Depart	any i		> Janelle	C. Henry	. HENRY F	uneral	Home, P. A. St. Cambr	aidae. N	10,2/6/3
	华		23a. Part Enter the disease, or com shock, or heart failure. List only	one cause on each line.		_ 1	or respiratory arrest,)	Approximate Interval Between Onset and Death
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Exan	niner		Sequentially list conditions,	b. It ypern.	atremia	·			
nted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or'as a conseque	ince of):				
/ou, te be executed	peen signed by the attending physician and should be detached for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequen	nce of):			- 1	
ficate be e	s the b	edicai	•	d					
The law requires that the death certifical	r use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de		,		23d. Date of de	
The dea	ched fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown	th 5 Other (specify)			Month	Day Year
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w requires t	phould	eted						2 No 3 P	
The law	age 2 s	Completed					24a. Was an autopsy performed	death?	utopsy findings available completion of cause of
clen: 1	ector, p	BeC	25. Was case referred to medical examiner?				1 ☐ Yes 2 ☑ th (Check only one)	NO 1 1 105	214140
Physi	ral dire	To	1 Yes 2 No		R/Outpatient 3 DOA Oth 8b. Time of 28c. Injur	4 Nursing no	ome 5 Residence		ocify)
ath.	ne fune	atior	t ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		Injury Wor	k? Yes 2 □ No			
af or Attending s after death.	ad in by th	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ural Route Number,
To the Hospital or Attending Physician: The law within 24 butus after death.	se runera	Medical (29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	edge, death occurred at the tir in and/or investigation, in my o	ne, date and place, pinion, death occur	and due to the cause red at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
To the	comp	ž	29b. Signature and title of certifier	Awy MD	29c. Licens	9 number 7 9 2 4		Date signed (Mont	
			30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)			. 72 - 0	
			NOMAN TIMANG	7 300 AURO	ORA ST C	AMBRIDE	GE MAD	216	13
R	Sta legistr	-	31. Date filed (Month, Day, Year) FEB 2 3	2005 32. Registrar's Signatur	H South				/

			For Stata Registrar	State of Maryland		artment of H		nd Mer		giene lag. No.	CHIL	07806
			1. Decedent's Name (First, Middle, La	st)					Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		THOMAS	JOSEPH	MILI	LER				18,	2005	12:43A M
	Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of	Death			County of Deat	
			Laurel Region			Laure		A Hea la				eorge's
	Funeral		5. Social Security Number 6. S	INDIM 2□E	as <i>t birthday)</i> Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day or . 14	r, Year)	9. Birt	hplace (State or Foreign
	Director	-	214-32-8573 Usual Residence of Decedent	69				AL) <u>r.</u> 14	, <u>19</u> .	33 Ma	ryland
	yland now		10a. State 10b. County		, Town or Lo							10d. Inside City Limits
	a-fsh	cto	MD Prince	George's Be	ltsvi	llle						1 [2 XYes 2 □ No
	or 28)ire	10e. Street and Number			10f. Zip Code				10g. Citiz	zen of What Co	ountry?
	238 1238	Funeral Director	8115 Muirkirk			207					U.S.A.	
	ar dez	une	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 Tyes 22No	5. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig ın, Mexican,	in? (Specify , Puerto Ric	/ Yes or No- an, etc.)		 Race - Ame Black, Whit 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:				Specify ${ m B1a}$	ck
5-0036	within 72 hours after death with the Maryland ene. han "natural", or Itams 23e or 28e-f show he Medical Eracili et nuel be notified al	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation			16b. Kir	nd of Business/	/Industry
212	hin 72	ple	(Specify only highest gr Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most	or working		Dx	ivate	
2121	ad witi	Completed		2yrs	Sł	nipping						
ng	ba file tal Hy d oth avant	Be	17. Father's Name (First, Middle, Las.						irst, Middle,		Sumame)	
<u>Y</u>	ould Men Parka	ဦ	George Mille		10h Maili	ng Address (Street			Wood		Town State	Zin Code)
Maryland	12 sh h and 7 Is n traun	E [19a. Informant's Name/Relationship Gladys Miller-			5 Muirki						
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itama 23a or 28a-1 show among injury or othar traumatic avant, the Mudical Exercities on at the notified at another.		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of	1	Date			cation - City or	
Baltimore,	ages ant of your of		1 ⊠ Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec	_Hemoval from State		matory or other place		/24/2	2005	Ta	urel,	MD
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m	Per Per Per Per Per Per Per Per Per Per		Colf	A showle	(:	246 N. W	lashi:	ngtor	n St	Roc.	kville	,MD20850
	*		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death one cause on each line.	n. De no t en	ter the mode of dyin	ig, such as	cardiac or re	spiratory ar	rest.		Approximate Interval Between
	Physician	Ŋ.	Immediate Cause (Final disease or condition	CEREBR	AL TI	HROMBOSI	S					Onset and Death MINS
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):							
В	LAGITITIE	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience of).							
	tad	nine	Cause (Disease or injury	240 (0 (0) 20 4 00)								
<u>,</u>	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C	uence of):							
8760,	sate be executad physician and the burial-transit			d								
9	certifical nding phy use as th	Physiclan/Medical	IC FEMALE:									
Вох	eath certifica attending plander for use as t	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Fetal	death 3[☐Ectopic pregnancy	,			2	23d. Date of de Month	livery Day Year
	0 0	sici	1 Yes 2 No	4□Pregnant at time of de 9□ Unknown	eath 5[Other (specify)						
P.0	hat the	Ph	Part II. Other significant conditions	contributing to death but not resi	ulting in the t	inderlying cause giv	en in Part I.		23e. Did to	obacco u	se contribute to	o the cause of death?
Vital Records,	w requires to been signer should be o	d by	HYPERTENS	_	-				1 🗆 Y	/es 2[□No 3 □ Pi	robabły 4½Unknown
COL	w requ	ompleted							24a. Was	an	24b. Were at	utopsy findings available completion of cause of
He	has has	mc								rmed? 2 XNo	prior to death?	V
tal	ician: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place	of Death (C	Check only o		1,0100	20110
<u> </u>	di S	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 npatient 2	ER/Outpatie	nt 3 DOA Oth	ier: 4□Nui	rsing Home	5 🗆 Resid	dence 6	5 □Other (Spe	ecify)
n of	Jing Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?		I. Describe h	now injur	y occurred	
Sio		catle	2 Accident investigati	ha -			Yes 2 1	-	Location /	244	d Number of O	ural Route Number,
Division		ertification;	4 Homicide determine		ome, farm, st	reet, factory, office		201	City or Tox	vn, State,)	arar nodie Wallber,
	e Hospital 24 hours a 8 Funaral E letely fillad	0	29a. Certifier	hysician: To the best of my kno	wledge, dea	th occurred at the tir	ne, date an	d place, and	due to the	cause(s)	and manner as	s stated.
	To the Hospital or At within 24 hours after or To tha Funaral Dirac completely fillad in by	edical	(Check only 2 Medical Exa	aminer: On the basis of examina and manner stated.	tion and/or it	nvestigation, in my o	pinion, deat	th occurred	at the time,	date and	place, and due	e to the cause(s)
	To the within 2 To tha complet	Ž	29b. Signature and title of certifier	1/1/2		29c Licens	e number			29d. Dat	e signed (Mont	th, Day, Year)
	/		* Wullace	~ 67 Was	ne	וע עי	241	16		Feb	ruary	18, 2005
	>		30. Name and address of person who				7.0000		C+ T~	1124 ~	1 MD	20707
		2.2	Dr. William A 31. Date filed (Month, Day, Year)				eorg	e s	эг га	ure	⊥, ™D	20707
	St Regist	ate rar	FEB 2 2 2	32 Registrar's Signal	4 As	all						

		1 - State of Maryland / Department / Department / Departmen	ent of Health and M ate of Death	lental Hygier Reg. t	211115 11 / 811 /
Physic		1. Decedent's Name (First, Middle, Last) ANNA Malinowsl	ki	2. Date of Death	3. Time of Death 2:55P M
/Medi Exami		4a. Facility Name (If not institution, give street and number) 4b. Cit Holy Cross Hospital	ty, Town, or Location of Death Silver Spring		4c. County of Death
Funeral Director		-	der 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea Aug. 23, 19	Montgomery 9. Birthplace (State or Foreign Country) New York
		Usual Residence of Decedent		1149.20715	
Maryla f show	ō	10a. State 10b. County 10c. City, Town or Location Langley Park			10d. Inside City Limits 1 ☐ Yes 2√∑ No
h the h r 28a-	irect		Zip Code	10g. (Citizen of What Country?
ath wit	raiD	8241 New Hampshire Avenue	20783		United States
perfullible; Mal yield within 2 Late 50000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Modical Execution to an other traumatic event, the Modical Execution to an opine.	by Funeral Directo	1 Never Married 2 Married 1 Yes 2 No	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	acify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
thin 72 hores	Completed	Flementary/Secondary (0-12) College (1-40r5±)	work done during most of worki use retired)	ng	Kind of Business/Industry
led wit hygiene her tha		- Indicated to			n home
id be fi ental H ked otl	o Be	17. Father's Name (First, Middle, Last) John Okiec	Mary) (First, Middle, Maid	zymowski
nd 2 shou alth and M 27 is mar	-		ess (Street and Number or Rura rthcrest Drive		or Town, State, Zip Code) oring, Md. 20904
Pages 1 and of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Accemetery, crematory of Metropolitan)	lame of rother place) Crematory 2/22		Location - City or Town, State exandria, Virginia
permit. Departn Imports any Injt		21. Signature of Juneral Service Licensee Dona 10 4400 I	and Address of Facility IV. Borgwardt Powder Mill Roa	Funeral H ad Beltsvi	ome, PA lle, Maryland 20705
	110	23a. Part1. Each the disease, or complications that caused the death. Do not enter the m shoot, if heart failure. List only one cause on each line.	ode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	ı	Immediate Cause (Final disease or condition resulting in death) a. Cardio ulmonary Arre	est		Onsor and Dodain
Examiner	ı	Coronary Artery Dise	ease		
be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): Hypertension			
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To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
hat the deby the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying	r cause given in Part I	23e Did tobacc	o use contribute to the cause of death?
requires t	d by	Taking one of the control of the con	, oadoo g.vo.v		2 No 3 Probably 4 Junknown
25 20	Completed	<u> </u>		24a. Was an autopsy performed?	
cien: ertifica ector, p	Be C	25. Was case referred to medical examiner?		(Check only one)	
Physic this or	5 T	1 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ EP/Outpatient 3 ☐ 1 ☐ Yes 2 ☐ Yes		me 5 Residence 28d. Describe how in	6 ☐ Other (Specify)
nding ath. r: After e funes	ation	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 2000120 11011	ary coodings
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he Hospit in 24 hour he Funare pletely fills	edical	29a. Certifier (Check only one) 1 XCertifying Physician: To the best of my knowledge, death occurred to the basis of examination and/or investigation and the stated.	ed at the time, date and place, a on, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	Σ	San market	D- 1137 9	2 .	Date signed (Month, Day, Year)
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	040	Margaret Snow, MD 9013 Flower Avenue Sil 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ver Spring, Ma	ryland 209	901
Regist	ate trar	2 21:05 FEB 2 2 2005 B	Total & April	ale I	

Amended **Physician** /Medical Examiner **Funeral** Director 28a-f show Director 23e or Funeral 5 þ "natural". Completed other than Maryland 1 and 2 should be Health and Mental Important: If item 27 Is any injury or other trau Department of Health **Physician** /Medical **Examiner** Physiclan/Medical Examiner use as the burial-Box 68760 physician P.O. | Records.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State #8, per/f. home, 2/25/0 Sertificate of Death E.T, WCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JOHN MOTSKO, 16,2005 Feb. 5.03 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Berlin Worcester Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1**⊠**M 2□F 86 190-03-2955 8-17-18 PΆ Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Worcester MD 1XYes 2 No Ocean Pines 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 253 Ocean Parkway 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Sexes 2 □ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elias Motsko Mary Mihalo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253 Ocean Pkwy., Ocean Pines, Md., Spouse 21811 Mary K. Motsko 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ⊠ Bemoval from State * 4 ☐ Donation 5 ☐ Other (Specify) Bernard's Cemetery 2-21 Indiana, Pa. 21. Signature of Fyeral Service Licensee 22. Name and Address of Facility MIL Berlin, Md. Ullrich Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition rene resulting in death) Due to (or as a consequence of) indiome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Wo 24a. Was an autopsy performed? page Vital 1 Yes 2 1 NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Tof Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2. No 1 Inpatient funeral dir 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year))53612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Healthung Dr Behi 9730 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2 2005 FEB Registrar

DHMH 17 Rev 1/2001

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Division

Vincent Macuro altimore, Maryland 21215-0036

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Box 68760,	
P.O.	
Records,	
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Division	

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	•	1 - For State Registrar			Certificate of			1. No.	07809
Physicia		1. Decedent's Name (First, Middle, Las	st)			-	2. Date of Death Month	Day Year	3. Time of Death
/Medic		Vincent Mauro			1, 0, 7		February	23, 2005	4:50 P M
Examin	er	4a. Facility Name (If not institution, give 360 Winding Oak D				or Location of Death		4c. County of Death	
Funeral		5. Social Security Number 6. S	ex 7. Age ((In yrs. last birti	Hagersto	ır If Under 24 Hrs.	8. Date of Birth	Washingto	n nplace (State or Foreign untry)
Director		007-12-9200	Ø M 2□F	83 Y	rs. Months Day	s Hours Min.	Sep. 16,	1921 New	York
and w		Usual Residence of Decedent 10a. State 10b. County	1	I Oc. City, Town	or Location				10d. Inside City Limits
Mary -f sho	ξ	Maryland Washing	ton	Hagers	town				1 ☐ Yes 2 ☑ No
or death with the Maryland tems 23a or 28a-f show ar must be notified at	Director	10e. Street and Number			10f. Zip Code)	10g	. Citizen of What Cou	untry?
ath wi	ral	360 Winding Oak D			21740			SA	
ter death w Items 23a	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 X Yes 2 ☐ No		13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
al', or	۾	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1975	1 ☐ Yes 2X☐ No	o Specify:		Specify: Wh	ite
within 72 hours after ene. than "natural", or Ite	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. I	Decedent's Usual Occi 'Give kind of work don life. DO NOT use retir	upation e during most of work	ing 16	b. Kind of Business/l	ndustry
within ane. than	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	·		red)			
filed Hygid other ent, I	Be Co	12 17. Father's Name (First, Middle, Last)		Mus	ician	18. Mother's Name	e (First, Middle, Ma	ilitary uden Sumame)	
Aental Aental rkad tic ev	ToB	Antonio	Mauro			Rosaria		De	eLucia
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Important: if item 27 is markad other than "natur any injury or other traumatic event, if a Medical 9069.		19a. Informant's Name/Relationship (7		19b.	Mailing Address (Stree	et and Number or Run	al Route Number, C		
1 and 1 and 1ealth 1m 27 ther tr		Phyllis A. Mauro 20a. Method of Disposition	(Wife)	360	Winding C	Oak Drive H	lagerstow	n. Mary Lar	nd 21740
ages nt of h t: If its		1 ⊠Burial 2 ☐ Cremation 3 ☐	Memoval Irons State		Disposition (Name of crematory or other pl	1	_	.07	
artma ortan injury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Services Licen 		Rivervi	ew Cemeter		26,2005 W	illiamspor	t.Maryland
permi Depa Impo any i		(Frate M	en_		St. Willi	ress of Facility Tuneral Hon Tamsport, N	ne P.A. 4. Maryland	25 S. Conc 21795	ococheague
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/Medical Examiner		resulting in death)	Due to (or as a o	consequence of	nt infec	1:			
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d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events	C						
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6 × 6	dicat		d						
certific ding p	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. Date of deliv	ven/
death e atter	iclar	in the past 12 months?	1□Live birth 2 4□Pregnant at tin		3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Month	Day Year
at the by the	hys	9 🗆 Unknown	9□Unknown						
res tha	۾	Part II. Other significant conditions of	-	not resulting in	1 7	given in Part I.	23e. Did tobac	cco use contribute to	
w require been si should I	Completed	Con Other 1	, , ,	(1215)	· p 1 - 0 cm /	marche)		
he law has ge 2 s	m d						24a. Was an autopsy performe	d? death?	opsy findings available ompletion of cause of
an: Ti	Be Co	25. Was case referred to medical				26 Place of Death	1 ☐ Yes SE	No 1 ☐ Yes	2 □ No
nysicia nis cer diract	To B	examiner? 1 ☐ Yes ② No	Hospital: 1 Inpatient	2 ER/Outp	patient 3 DOA	ther		e 6 ☐Other (Speci	(fy)
ng Pt		27. Manner of Death ✓ Natural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Ti	ury W		28d. Describe how	injury occurred	
ttendi death. stor: A	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		At home for		☐Yes 2☐No	29f Location /Stron	et and Number or Rur	al Pouto Number
after Direction by	Certification:	4 ☐ Homicide determined	building, etc. ((Specify)	n, street, factory, office	9	City or Town, S	State)	ai noute Number,
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral diractor, page 2 should be detached for use as the		29a. Certifier Certifying Ph	ysicien: To the best of r	my knowledge,	death occurred at the	time, date and place,	and due to the caus	se(s) and manner as s	stated.
the Hin 24 the Figure 1	Medical	one)	niner: On the basis of ex and manner state						
To To con		29b. Signature and title of certifier	Kno		29c. Licer	11940	1	Date signed (Month,	
		30. Name and address of person who	completed cause of dea	th (Item 23a) (T	vpe, Print)	10 170		10-2 (-	200
H-7+1		W. E. Kutzera,	WD 747	No.	theen Av	le Hagi	erstown	mo a	41742
Sta Registra		31. Date filed (Month, Day Your)	2005 32. Régistrar's	s Signature	Courtes	7			
riegioti	-14		P .						

			_ FOI	artment of Health and Me	ental Hygien	2000 07010
	Physicia /Medic	al	Decedent's Name (First, Middle, Last) Marcia Iva Milburn 4a. Facility Name (If not institution, give street and number)		ebruary 2	Day Year 3. Time of Death 22 2005 M. County of Death
	Examin Funeral Director	Ç.	419 Beth lehem Court 5. Social Security Number 6. Sex 1 □ M 2XF 7. Age (In yrs. last birthday 84 Yrs.	Hagerstown	8. Date of Birth (Month, Day, Yea, 192	Washington
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28e-f ehow eny injury or other treumetic event, the Modical Examiner mast be rediffied at Once.	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Married 3 Midowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 17. Father's Name (First, Middle, Last) Calvin Henry Stoner 19a. Informant's Name/Relationship (Type, Print) Linda L. Harsh — Daughter 20a. Method of Disposition 1XXeurial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Center 1 1 1 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3	Hagerstown 10f. Zip Code 21740 Was Decedent of Hispanic Origin? (Specify Section of Work Cone during most of working DO NOT use retired) Housewife 18. Mother's Name Margaret Margaret Margaret Margaret 44 Falling Waters F	g 16b. (First, Middle, Maide Route Number, City Road Williate 20c. 5,2005 Shape, P.A.	eth Kaetzel vor Town, State, Zip Code) iamsport.M. 21795 Location - City or Town, State arpsburg, Maryland
1760,	Wedical Examiner	ical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lary, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Peath
.O. Box 68	death certifica e attending ph ed for use as th	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P	aw requires that been signed as should be de	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital R	tending Physicien: leath. tor: After this certifice the funeral director, p	Certification: To Be Cor	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time Injury (Month, Day Year) 28b. Place of Injury - At home, farm, so building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No	1 Ves (Check only one) 1 Residence 8d. Describe how inj	1 ☐ Yes 2 No 6 ☐ Other (Specify) jury occurred and Number or Rural Route Number,
ia	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical Cer	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stayled. 29b. Signature and the oil certifier	nvestigation, in my opinion, death occurre 29c. License number	d at the time, date a	and place, and due to the cause(s) Date signed (Month, Day, Year)
7	ローロ Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type F. Sack 1997) (31. Date filed (Month, 1997) (2005) (2005) (32. Registrar's Signature	print) 9 St. Paul St	· Booms	bruary 22,2005 bara, MD 21713

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of	Maryland		artmen			and M		Reg. No.	05	07811
	Physici /Medio		1. Decedent's Name (First, Middle, L	TOV-PE	pluik	.0					2. Date of Dea	Day	200	3. Time of Death 5 12 like AM
	Examir		4a. Facility Name (If not institution, g	101	oer)		4b. City,	Town, or	Location o			4 /	inty of Death	
			KANdolph F	tills	A == //a /a		S/I	ER	If Under 2	LNG	0.0-1			GOMERY
	Funeral Director		5. Social Security Number 6. 071–34–3857	Sex 7. 1 □ M 2 1 F	Age (In yrs. Ia:	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt Month, Da NOV II	, 1918		nplace (State or Foreign SEKISTAN
	70		Usual Residence of Decedent											
	anylan show	_	10a. State 10b. County			Town or Lo								10d. Inside City Limits
	8a-f.	octo	MARYLAND MONTGOM	ERY	KENSI	NGTON								1 X Yes 2 □ No
	with 11	ä	10e. Street and Number 3707 EMILY ST.				10f. Zip					10g. Citizen USA		untry?
	heath	eral	11. Marital Status	12. Was Deced	ent Ever in U.S	. 13.			spanic Orio	gin? (Spe	cify Yes or No-		Race - Amer	ican Indian,
(0	ifter d	FF	1 ☐ Never Married 2 ☐ Married	Armed Forc	es?					, Puerto	cify Yes or No- Rican, etc.)		Black, White	e, etc.
5-0036	72 hours after death with the Maryland naturel', or iteme 23e or 28a-f show digal Evanir at must be profified at	Completed by Funeral Director	3X Widowed 4 □ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	No No	Specify:			Spe	cify:WHI	TE .
5	72 h natu	etec	15. Decedent's (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	tion uring most	of worki	ng	16b. Kind o	f Business/I	ndustry
2121	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4	or 5+)	PROFE		e retired)			,	EDUCA	TTON	
d 2	filed Hygie other	ပိ	17. Father's Name (First, Middle, Las			IKOFI	BBOK		18. Mothe	r's Na <i>m</i> e	(First, Middle,			
an	ld be lental ked o	To Be	ANATOL TICHOTSKY						WERA	KRI	MSKY			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or iteme 23e or 28a-f show any injury opether traumatic event, the Medical Evantinet must be notified at once.		19a. Informant's Name/Relationship ROBERT FIRSCHING		ON	19b. Mailii 3707	ng Address EMILY	(Street a	nd Numbe KENS	r or Rura	Poute Numbe	or, City or To 20895	wn, State, Z	ip Code)
Baltimore,	Pages 1 a nent of He nt: If item		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		ate cer	netery, crei	osition (Naminatory or of	her place			2005	20c. Location		
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Lic	ensee Num	du	100								HOME INC.
8760,	Physician pe executed duling physician and physician and physician and physician at the purial-transit	licai Examiner	23a. Part1. Enter the disease, or co shick, or heart failure. List on Immedian cluse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or frijury that initiated events resulting in death) Last	a. FAILUR Due to (or	ised the death. th line. E TO TH. as a conseque as a conseque as a conseque	IRIVE ence of):	er the mode	e of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Batween Onset and Death 4 WEEKS
O. Box 6	law requires that the death certificate as been signed by the attending phy. 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pyegnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ∏ Fetalo nt at time of dea	leath 3	∃Ectopic pre ∃ Other (spe						Date of delive	very Day Year
rds, P	quires that n signed t	d by P	Part II. Other significant conditions DEPRESSION, CER						n in Part I.			obacco use c res 2 🗆 No		the cause of death?
Records,	The law requir ate has been si page 2 should	Completed by											b. Were aut prior to o death? 1 Yes	opsy findings available ompletion of cause of
Vital	ysicien: The l is certificate ha director, page	Be C	25. Was case referred to medical examiner?							of Death	(Check only o			
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'n	ling F	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	8b. Time o Injury	M 2	Bc. Injury Work	at ? 'es 2⊡1		28d. Describe h	iow injury oc	curred	
Division	Attending r death. sctor: After by the fune	icat	2 Accident investigati 3 Suicide 6 Could not	be 390 Place o	f Injury - At hom	ne farm str			65 Z []		28f Location (S	Street and Nu	mber or Rui	ral Route Number.
Οį	after Direction by	Certification:	4 ☐ Homicide determine	building	, etc. (Specify)	10, 141111, 011	oot, ractory	, 011100			City or Ton			a. 110010 110111201,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	edical C	29a. Certifier (Check only one) Check only 2 Medical Ex-	Physician: To the basaminer: On the basand manne	is of examination	ledge, deat on and/or in	h occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	words	Den	n.M		License		763	30	29d. Date sig		
			30. Name and address of person who DR. ARUN 10301				,				20906			
	Sta Regista		31. Date filed (Month, Day, Year) FEB 2 2	2005	gistrar's Signatu	re do	alle							

	F	•	State of Maryl State Registrar		artment rtificate			ind Me		ene 00	5 07812
	Physicia	an	Decedent's Name (First, Middle, Last) Leona Mae Neal						2. Date of Death	, ¤2005 [×]	3. Time of Death 8:44 PM M
ī	/Medic Examin		4a. Facility Name (If not institution, give street and number)				Location of			4c. County of	
			5801-C Bells Lane 5. Social Security Number 6. Sex 7. Age (In.)	yrs. last birthday)	If Under	deri 1 Year	.C.K. If Under 2	24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director		217-30-5722 1□M 2ĂF 88	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Day, July 8,	^Y •¶916 [Mary Land
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo							10d. Inside City Limits
	e Many Be-fsh diffed	Director	Maryland Frederick	Frederi							1 Tes 2 No
	3a or 2	i Dire	10e. Street and Number 5801 - C Bells Lane		10f. Zip	21	704		10	U.S.A.	at Country?
036	be filed within 72 hours after death with the Maryland tal Hyglene d other than "naturel", or Items 23a or 28e-f show event, The Madical Exerteins Front Let Adilised at	by Funerai	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec	**	spanic Orig n, Mexican Specify:	in? (Spec Puerto P	cify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. White
<u>2</u>	natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deceo (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition furing most	of workin	g 1	6b. Kind of Busin	ness/Industry
1212	d within glene. ir than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		omemal		,			Own Ho	me
Maryland 21215-0036	be d state	To Be C	17. Father's Name (First, Middle, Last) Elmer Clarence Jacobs							aiden Sumame) ne Bruch	ey
Mary	s 1 and 2 should of Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Mrs. Kelly L. Breznai, Granddau							City or Town, Start, MD 2	
Baltimore,	Pages 1 a nent of Hei ant: If item ury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 4 Donation 5 Other (Specify)	b. Place of Dispo cemetery cren fount Olive	et Ceme	tery	- 1	n 5, 2	2005	Oc. Location - Cit Frederic	ck, MD
Bait	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee MOC	0255 K	Name and LO6 Ea	Addres and ast (s of Facility 1 Bas 2hurc1	ford h St.	PA Fune Frede	ral Home rick, M	<u>5</u> 21 7 01
ı,			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	death. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or a a condition)	CARDI	IAL	1S	CHE	- 14	14		
V.	Examiner	-	S uentially list conditions. If any, leading to immediate b. CHOLA	MG (O	CAR	CIr	10r	14			month
Γ	cuted od ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Ex	resulting in death) Last Due to (or as a cor	sequence of):							
9	ing phy e as the	Medic	IF FEMALE:								
Вох	death certific a attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Vec 2 Man 4 2 4 Pregnant at time	Fetal death 3	Ectopic pre					23d. Date of Month	',
0	res that the de signed by the a be detached f	Phys	9 ☐ Unknown Part II. Other significent conditions contributing to death but not	t require a in the	adash iya as		o io Dani I		230 Did tob	accourse contribu	ute to the cause of death?
rds,	quires the n signeral be d	by	Cancer Eachering		riderlying Ca	iuse give	iiiiran.				Probably 4 Unknown
Records,	law require as been signs 12 should b	Completed							24a. Was an autopsy	prio	re autopsy findings available or to completion of cause of
al H		е Соп	25. Was case referred to medical							No 1	th? Yes 2 No
f Vital	d is	To Be	examiner? Hospital:	2 ER/Outpatien	nt 3 DO	A Othe	-		(Check only one	nce 6 Other	(Specify)
on of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending (Month, Day Yea	28b. Time of Injury	f 28	Bc. Injury Wark	at :? /es 2 🗆 N		8d. Describe ho	w injury occurred	
Division	ten feat for: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S)				.00		8f. Location (Str. City or Town,	eet and Number (State)	or Rural Route Number,
_	Hospite 4 hours Funeral	edical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my one) 14 Certifying Physician: To the best of my one and manner stated.	knowledge, death mination and/or in-	h occurred a vestigation,	at the tim in my op	e, date and binion, deat	d place, a h occurre	nd due to the ca d at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier		29c.	License	number	CIL	29	d. Date signed (A	Month, Day, Year)
•			30 Name and address of person who completed cause of death	(Item 23a) (Type	Print)	04	417	9		March 2,	2003
	4		A-Z. HEGHZI 46 B	Thom	as s	ohn	500	DV	me t	farch 2,	2170Z
	Sta Registi		31. Date filed (Manth Day, Year) MAR 0 8 2005	ignature	15						

			1- For State of Maryland /				d Mental Hy	giene nns	07813
			Registrar	Cert	tificate of	Death		Rag. No.	07010
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De.	Day Year	
	/Medic	al	Frances Pope joy		4b. City, Town, o	r Logation of C	FEBRUAR	4c. County of Dec	
	Examin	er	4a. Facility Name (If not institution, give street and milmber) DOTCHESTER GENERAL HOSPI;	tal	Cambri		- Gaur	Dorch	
-	Funeral		5 Social Security Number 6 Sey 7 Age (In urs last h	pirthday)_	If Under 1 Year	If Inder 24			rthplace (State or Foreign country)
	Director		456-34-7108 1 M 2 M F 79	Yrs.	Months Days	Hours M	Min. (Month, Da March	2, 1925	Texas
_	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Loc	ation				10d. Inside City Limits
7	shor	ō							1 ☐ Yes 2 ☑ No
)	28a-f	Director	Maryland Dorchester 10e. Street and Number	MOOT	Lford 10f. Zip Code			10g. Citizen of What C	country?
)	3a or	٥	1648 Taylors Island Road			677		-	SA
	death with the Maryland ims 23a or 28a-f show r must be rudified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	1		? (Specify Yes or No uerto Rican, etc.)		erican Indian,
0	after or Ita	/ Fu	1 Never Married 2 Married 1 Yes 2 No	1	☐ Yes 2 No	Specify:	401.0 1110411, 010.7	Specify:	
2-003c	hours tural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			-41		W	nite
ς C	within 72 ene. than "nat	lete	(Specify only highest grade completed)	(Give k	ent's Usual Occup rind of work done O NOT use retire	during most of	working	Industria	•
7	iene iene r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Ent	reprene	ir		Manufactur	
D	e filled Il Hyg other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Sumame)	
/land	should be and Mental markad c umatic av	To E	Jack Stiers Allen			Fran	ces Purka	ple	
Mar	d 2 should be filed within 72 hours after death with the Marylar it and Mental Hygiens. It and Mental Hygiens to the streams 23e or 28e-f show at a marked other than "natural", or Itams 23e or 28e-f show traumatic avant, the Medical Evant are must be notified at			•	•			or, City or Town, State,	Zip Code)
	s 1 and if Health itam 27 othar ti		John Richard Popejoy, Jr./Husband 20a. Method of Disposition 20b. Place				olford, MD	21677 20c. Location - City o	r Town State
פֿב	ages 1 an nt of Heal : If itam 2 or othar		1 Burial 2 Cremation 3 Bemoval from State		ition (Name of atory or other pla	1		·	
daitimore,	mit. Pages partment of h cortant: If its r injury or or		. 4 □ Donation 5 □ Other (Specify) MldSt 21. Signar e of Funeral Service Licensee	22.	Name and Addre	ss of Facility	2/21/200		e, MD
n	Dr. p.		Kaller Herral- Honura	21 St	rran-Br	omwelĺ	Funeral H mbridge,	ome, PA	
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dyir	ng, such as car	diac or respiratory a	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ctron	1 ///	n Fa	luce		Onset and Death
	/Medical		resulting in death)	e of):	0199	1 47	TOIC		1
	Examiner		Sequentially list conditions, b. 167, Chera		Vaser	1/9r 1	2150950	2	Years
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury the initial additional cause)	e ot):					100
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last Due to (or as a consequence	e of):					
9/	te be ey ysician se buria	calE							
2	4 T =								
ŏ	leath certific attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat	ıth 3⊡f	Ectopic pregnanc	у		23d. Date of de Month	olivery Day Year
o.	at the dea by the at tached fo	sicl	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 1 □ Yes 2 □ No 9 □ Unknown	5 🗆	Other (specify)			WOITH	Day
<u>.</u>	hat th od by detach		Part II. Other significant conditions contributing to death but not resulting	a in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ds,	law requires that the as been signed by th 2 should be detache	d by	Coronary Actory Dispose	•	,		, 10	Yes 2 □ No 3 □ F	robably 4 Haknown
ecord	w requ been shoulk	Completed	Tintachtach Pulmanaga	F. h	COC 16-		24a. Was	an 24b. Were a	tutopsy findings available
Ĕ	sician: The law s certificate has b lirector, page 2 s	dmo	Darla da Mail da 5	10	20515		autor perfo	med? death?	
Vital	an: T tificat tor, på	Ф	25. Was case referred to medical			26. Place of	1 ☐ Yes Death (Check only of	20.10	5
	2 .2 0	To B	examiner? 1 Yes 2 No	Outpatient	3□ DQA Ott			dence 6 Other (Sp	ecify)
n of	fte		27. Manner of eath 28a. Dite of Injury (Month, Day Year) 28b.	. Time of Injury	28c. Inju		28d. Describe	now injury occurred	
Sio	ttandi death. ctor: A y the fu	catl	2 Accident investigation	,]Yes 2□No	206 Leasting (Street and Mumber of E	Pure / Causta Alumbas
Division	or At after of Dirac in by	Certification;	4 Homicide 4 Homicide 4 See Place of Injury - At home, building, etc. (Specify)	tarm, stre	et, factory, office		City or To	Street and Number or F vn, State)	iurai noute ivumber,
_	ours a		29a. Certifier Certifying Physician: To the best of my knowledge	lge, death	occurred at the ti	me, date and p	lace, and due to the	cause(s) and manner a	as stated.
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	edical	(Check only 2 Medical Examiner: On the basis of examination a and manner stated.						
	To th within To th comp	Ř	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mor	oth, Day, Year)
			Vuyene Man DD		145	1793		2/17/0	5
			30. Name and address of person who completed cause of death (Item 23a	a) (Type, F	Print)	-	CI	011	110 211.5
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	10	503	241	n)T (amprida	· MD 21613
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2. 2 2005	1 6	posts			/	
				-/					

			1- State of Maryland / Department of Health and M Certificate of Death			07814
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia		Harold Lee Phillips	Month	Day Year	1050 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	1
			13008 Blairs Valley Road Clear Spring	Ţ	Vashingtor	County
	Funeral		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birti Co	place (State or Foreign intry)
	Director		213-40-4250 G4 Yrs. Usual Residence of Decedent	October '	7 1940 M	ryland
	yland yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar	ctor	Maryland Washington Co. Clear Spring			1 ☐ Yes 🏂 ☐ No
	or 28	Dire	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
	s 23a	rai	13008 Blairs Valley Road 21722		nited Stat	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at 90se.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Forces? 1 □ Yes 2 ☑ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
5	72 hc netu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)	ing 168	o. Kind of Business/	ndustry
121	within and and and and and and and and and an	ldm	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Vice President of Mark	oting II	ome Mfg.	
	filed Hygid Sther ent,	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name			
a	should be filed with Mantal Hygiene. marked other the matic event, the	To B	Wilbur Jack Phillips Gladys	Reeder		
Maryland	2 shou and A Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
	1 and 2 Health tem 27		Kay A. Phillips (wife) 13008 Blairs Valley R			
Baltimore,	iges 1 nt of H if ite or ot		1 XBurial 2 Cremation 3 Removal from State R1 3 THE TOTAL OF THE PLACE IN THE PLACE		. Location - City or	
불	it. Pa ortmer ortant njury		'4 □ Donation 5 □ Other (Specify) Church of God Cemetery Feb 21. Signatur → Fuheral Service Licensee			
Ba	permit. Pages 1 an Depertment of Heal Important: If item 2 eny injury or other 2008.		Daniel O. Pauley or 1331 Eastern Blvd. N	I. Hagerst	cown Mary	and 21742
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)			10 month
п	Examiner		Due to (or as a consequence of):			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	icate be executed physician and s the burial-transit	Examin	Cause (Disease or Injury that initiated events c.			
60,	be exectan a	EX	Due to (or as a consequence of):			
38760,		dical	d			
Box (law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 1 □ Decrify 1 □ Decr		23d. Date of deli	very Day Year
P.O.	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
	es that igned b be deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should t			1 🗆 Yes	2 ☑ No 3 □ Pro	bably 4 □Unknown
of Vital Records,	The ate har page	Completed		24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of 2 No
Zi.	sicien certifi rector	Be	25. Was case referred to medical examiner? Hospital:			
	Physer this eral d	J: To	1 Yes 2 No	ne 5 Residence 28d. Describe how i		fy)
on	nding ath. r: Afte e fun	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Ru tate)	al Route Number,
	pital		29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place a	and due to the con-	-(-)	
	ve Hospital 24 hours a se Funerel I	Medicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the caused at the time, date	e(s) and manner as and place, and due	o the cause(s)
	To the I within 2. To the I complet	M	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month	Day, Year)
			Michael J. Meland MD 941667		2.24	.05
ال	4-8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	vs Hes	critim 1	no
	Sta Registr		31. Date filed (Month, Pay, Year) TEB 2 4 2005 32. Registrar's Signature	V		

			For State Registrar	State of Mary	•	artment ertificate			and M	•	giene	005	07815
	Dhusisi		1. Decedent's Name (First, Middle, La	ist)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Hazel Larue Pear							2 - :	21 - 2	005	12:05p M
	Examin	er	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, T	own, or	Location o	f Death		4c. Co	ounty of Death	1
	Funeral		RAVENWOOD LUTHE 5. Social Security Number 6.		yrs. last birthday) If Under		If Under 2	24 Hrs.	8. Date of Birt	h W	ASHINGT 9. Birth	FON place (State or Foreign intry)
	Director		220-16-3442	1□ M 2 X F	81 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Nov • 9	1923	Mary	intry) 1and
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L								10d. Inside City Limits
	d within 72 hours after death with the Maryland jone rt than "natural", or Itams 23a or 28a-f show the Modical Examirer must be mailfied at	o.											1 ☐ Yes 2 ☑ No
	the N	Funeral Director	Maryland Washing 10e. Street and Number	gton	Hagerst	10f. Zip	Code				10g. Citize	n of What Cou	intry?
	with 3a or	흅	1109 Luther Driv	·e			1740				USA		
	ms 2:	era	11. Marital Status	12. Was Decedent Eve	r in U.S. 13			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ameri	
ဖွ	or Ita	II.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give		1 Yes, speci		n, mexican Specify:	, Риепо н	Rican, etc.)		Black, White, pe <i>cify:</i> Wh:	_
93	ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:									
15	"nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Deci (Giv life.	edent's Usual e <i>kind of worl</i> DO NOT us	Occupa k done d retired)	ition iuring most	of working	ng	16b. Kind	of Business/Ir	ndustry
212	withi iene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ine Op					S	ilk Mi	11
Þ	filed Hyg othsi	Be C	17. Father's Name (First, Middle, Las	t)	,				r's Name	(First, Middle,			
/ar	uld be Menta rrked	To B	Emmert Newton E	verhart				Bes	ssa l	Lena Lo	uderb	ack	
lar)	2 sho and 1 Is ma		19a. Informant's Name/Relationship		19b. Mai	ling Address	(Street a	nd Numbe	r or Aura	Route Numbe	er, City or T	own, State, Zij	p Code)
2	and ealth m 27 har tr		Frank Clopper/PO							gerstow			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "nn any fijury or other fraumatic event, Ite Medions.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Tuelinovarinouri State	20b. Place of Disp cemetery, cre					ate		tion - City or T	
Ë	ntmen rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service L	fy)	Rest Hay								Maryland
Ba	perm Depa Impo any I		21. Signal of 1 different desires	5						t Haver			napel Md 21742
			23a. Part1. Enter the disease, or cor	nplications that caused the								.Scowii,	Approximate Interval Between
	Pnysician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	uan V	71 - 011	00.	01	90,7	lent-			Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a co		vo au	WV	0((- 4 6	aut-			IMOUIL ,
- 8	Examiner	,	Sequentially list conditions.	b									
	ait sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):								
	and and Il-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):								
760,	ate be executed hysician and the burial-transit	icai E		ri									
	ifficate g phy as the	ledic		V.									
Вох 68	death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		□Ectopic pre	anancy				230	d. Date of deliv	•
.O.	at the dea by the atl	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown		Other (spe						Month	Day Year
۵	that the		Part II. Other significant conditions	contributing to death but o	ot resulting in the	underlying ca	use dive	n in Part I		23e. Did to	obacco use	contribute to (the cause of death?
Hazel ecords,	88 LD 00	d by				anasnying oa	g. v c				/es 2□1		bably 4 Dunknown
Hazel cords	w require s been si should I	ompieted								24a. Was	an 2	24b. Were autr	opsy findings available
ле Ве	The lav	omp								autop perfor 1 ☐ Yes	rmed? 22 No	prior to co death? 1 Yes	empletion of cause of
Larue Vital R		Be C	25. Was case referred to medical					26. Place	of Death	(Check only o	×	10,763	20.140
of V	hysician: his certific I director,	10 8	examiner? 1 🗆 Yes 2 💆 No		2 ER/Outpatie		and the latest states	4 Nui	rsing Hon	ne 5 Resid	ience 6 [Other (Speci	fy)
AN	ttsnding Physideath. stor: After this crite the funeral dir	iuoj	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time (Injury		Bc. Injury Work			8d. Describe h	now injury o	ccurred	
PEARMAN Division	Attendl death. ctor: A y the fu	icat	2 Accident investigate 3 Suicide 6 Could not	De Glass of Injune	At home form e	M treet factory		es 2□N	-	8f Location /9	Street and N	Jumber or Rur	al Route Number,
PE/	after d after d Diract d in by	Certification:	4 ☐ Homicide determined	building, etc. (5	Specify)	treet, ractory,	ottice		-	City or Tow		and of Flan	ar route reamon,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best of m	y knowledge, dea	th occurred a	t the tim	e, date and	d place, a	nd due to the	cause(s) an	d manner as s	stated.
	the Hin 24 tha Fi	Medical	one)	miner: On the basis of exa and manner stated	amination and/or i				in occurre				``
	With Conf.	2	29b. Signature and title of certifier	a Minol			License	210	_			signed (Month,	
			Monten	7	(1)	Dala D	10	201				-22	~J
-3	1-5		30. Name and address of person who	Suppleted cause of death	368 7	ull &	ftru	el-1	Hey	stone	MD	2174	0
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 3	2005 32. Gegistrar's	(Item 23a) (Type 368 7) Signature	bertes							

		1	1 - State Registrar	of Maryland / Depa	artment of Health a		ene 005	07816
	Physici		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Maria Pobol 4a. Facility Name (If not institution, give street and Laurel Regional	1 spital	4b. City, Town, or Location of	Death	4c. County of Death	eoge's
	Funeral Director		5. Social Security Number (6. Sex 1 ☐ M 2)(1)	7, Age (In yrs. last birthday) 86	If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth (Month, Day,) June 22,	Year) 9. Birthp Coun 1918 P	lace (State or Foreign try) oland
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince George	s Lanham	ocation			0d. Inside City Limits
	with the	Director	10e. Street and Number		10f. Zip Code 20706	100	g. Citizen of What Coun USA	itry?
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at	by Funerai	1 Never Married 2 Married 1 Yes.	Forces?	Was Decedent of Hispanic Origif Yes, specify Cuban, Mexican 1 ☐ Yes Yes No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed in the complete state of	e (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most DO NOT use retired) embly Line		6b. Kind of Business/Inc	dustry
Maryland 2	12 should be filed within 7. h and Mental Hygiene. 7 is marked other than "n traumatic event, the Mad	To Be Co	17. Father's Name (First, Middle, Last) Alexius Kucyk	, noo	18. Mother	rs Name (First, Middle, Ma	aiden Sumame)	
ary	and Me	ř	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Numbe			
	t Health item 27 other tra		Alexander Lakomyj, Son 20a. Method of Disposition	20b. Place of Dispo	Cipriano Road,		ryland 207 Oc. Location - City or To	
Baltimore,	Pa Pa	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr '4 ☐ Donation 5 ☐ Other (Specify) 21. Sign 1973 ○ Funeral Service Licensee	MD Veter	ans Cemetery 0			
Ba	permit. Departr Imports any inju		V Janille Try 101	373	4739 Baltimore	Avenue, Hyat	ttsville, M	
	Pnysician /Medical		23a Parti. Enter the disease or complications the shock, or heart failure. List only one cause of limmediate Cause (final disease or condition resulting in death)	on each line.	ter the mode of dying, such as a	cardiac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner	Iner	cause. Enter Underlying	to (or as a consequence of):				
8760,	certificate be executed uding physician and use as the burial-transit	dicai Examlner	that initiated events	to (or as a consequence of):				
O. Box 68	death certific e attending p id for use as	Completed by Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
rds, P.	requires that the een signed by th hould be detache	d by Ph	Part II. Other significant conditions contributing Atherosclevotic C/	4	11 - 70	23e. Did toba	acco use contribute to the	ne cause of death? ably 4 []Unknown
of Vital Records,	aw 2 s s	ompiete	Vertigo			24a. Was an autopsy performe	prior to cor	psy findings available inpletion of cause of
Vita	Physician: The i this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	-	Other	of Death (Check only one)		
	ding Phys h. After this funeral di	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Scident investigation	Unpatient 2 ☐ ER/Outpatie ate of Injury Month, Day Year) 28b. Time of Injury	11 30 DOX 40110	rsing Home 5 Residen 28d. Describe how	v injury occurred	ell at
Division	- B E C	Certification;	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, farm, st uilding, etc. (Specify)	reet, factory, office	City or Town,	eet and Number or Rura State) 6040 Ca	priors
	To the Hospital or within 24 hours at To the Funeral D completely filled in	edical ((Check only 2 Medical Examiner: On the	the best of my knowledge, deanle basis of examination and/or in nanner stated.	th occurred at the time, date and ovestigation, in my opinion, deat	d place, and due to the cau th occurred at the time, dat	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To th To th	Me	29b. Signature and title of certifier Autorealt April	54,00	29c. License number		d. Date signed (Month,	
R	15)		30. Name and address of person who completed Salvador Sylva Reg	cause of death (Item 23a) (Type 300) Hospi	. 0	Cheverle	et many Many	land
	St. Regist	ate rar	31 Date filed (Month Day Year)	2. Registrar's Signature	e l		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

	Please T	ype or Pri	nt in Rla	ack In	delible lnk	Engur	e All Con	ies Are	l egible			
	i iodoc i				artment of H				_	•		
For State		Otate of W	arytana		rtificate of		i wichtai		N -075 -075 -0140	(1) top (5) 1 top		
Registrar 1. Decedent's Nam	ne (First, Middle, Last)				inouto or		2. Date	Reg. No	005	3. Time of Death		
	ROBERTA TA		LEY				Mont		11 1200	- 1 / / Ou		
	(If not institution, give s				4b. City, Town, o	or Location of			County of De			
MCMOT 5. Social Security	iai Flospi Number 6. Sex	tal at	EQ5+C	t birthday)	EQ51C	If Under 24		of Birth	9.8	irthplace (State or Foreign		
218-14-4	291 ¹]M 2 ∏ F	88	Yrs.	Months Days	Hours		10, 1		Country)		
10a. State	10b. County		10c. City, 1	Town or Lo	ocation					10d. Inside City Limits		
MD	QUEEN AN	NE'S	CHES'	TER						1 ☐ Yes 2 No		
10e. Street and Nu	ımber				10f. Zip Code			10g. Cit	izen of What	Country?		
120 DUND	DEE AVENUE				21619			US	A			
	rried 2 Married	12. Was Decedent Armed Forces 1 \(\text{Yes} \) 2 \(\text{Y} \) If Yes, Give Year or Dates:	? :No	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. WHITE		
	15. Decedent's Educatify only highest grade	cation		16a. Dece	dent's Usual Occup	pation during most of	of working	16b. K	ind of Busines	s/Industry		
Elementary/Sec		5+)	life. DO NOT use retired)					EPT. OF NATURAL ESOURCES				
17. Father's Name	(First, Middle, Last)					18. Mother	s Name (First, N	liddle, Maiden	Sumame)			
FRANK SE	TH TAYLOR,	SR.	_			ELIZA	BETH TER	RESA SC	HLEICH	ER		
19a. Informant's N	Name/Relationship (Ty	рө, Print)		19b. M ailir	ng Address (Street	and Number	or Rural Route N	Vumber, City o	or Town, State	, Zip Code)		
LORRAINE	E HADDAWAY/	DAUGHTER	(1)	115 S	TATION L	ANE, S'	TEVENSVI	LLE, M	D 216	66		
	sposition 2 □ Cremation 3 □ R 5 □ Other (Specify)	emoval from State	cem	etery, crer	osition (Name of matory or other pla		Date 2/25/200		vensvii	or Town, State		
21. Signature on	Funeral Service License	7/0	2.	F	ELLOWS, O6 SHAMR	HELFEN	BEIN & N AD, CHES	IEWNAM STER. M	FUNERAL D 216	L HOME, P.A.		
23a. Part1. Enter shock, or he Immediate Cause disease or conditi resulting in death)	ion	ne cause of each	istole	Do not ent	er the mode of dyi	ng, such as ca	ardiac or respirat			Approximate Interval Between Onset and Death		
		Due 10 (01)	cardi	opul	money	arre	5/-					
Sequentially list of larry, basing to cause. Enter Und Cause (Disease of that initiated even resulting in death)	derlying or injury	·	s a consequent s a consequent		lmono Umono	emb	belus					
IF FEMALE: 23b. Was decede	in pregnant	dd. 3c. If yes, outcome 1 □ Live birth	e of pregnanc		Ectopic pregnanc	v			23d. Date of d	,		
in the past 1; 1 Yes 2 9 Unknow	. ₩No	4∏Pregnant a 9∏Unknown			Other (specify)	,			Month	Day Year		
. /	ificant conditions cor	-		ng in the u	nderlying cause gr	ven in Part I.	23e.	Did tobacco		to the cause of death? Probably 4 Unknown		
40	pocalce	nia					24a.	Was an autopsy	prior to	autopsy findings available completion of cause of		
/-	Atrial Fre	brilotion					10	performed? Yes 22 No	death	es 2 No		
25. Was case reference examiner?	/	fospital: 1 Inpat		VOutpatier	nt 3 DOA Ott	hor	of Death (Check	only one)	1.	pecify)		
27. Manner of Dea 1 ☑ Natural 2 ☐ Accident		28a. Date of inj (Month, D	ury 28 ay Year)	Bb. Time of Injury	f 28c. Inju Wo	ry at	28d. Des	cribe how inju				

Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed P After this funeral c

Be Completed by Physician/Medical Medical Certification:

1 - For State Registrar

Physician

/Medical

Examiner

Funeral Director

To Be Completed by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, It a Medical Examinar must be notified at once.

within 24 hours after death.

To the Funaral Director: A completely filled in by the fu

LAURA JIN, M.D. State

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier Horoy Laura

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21601

D 55484

2-22-2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

219 S. WASHINGTON STREET, EASTON, MD
3 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

_			1 - State of Maryland / Department of Health and N Certificate of Death		ene 005 07818
	Physici		1. Decedent's Name (First, Middle, Last) MARY E. ROBINSON	2. Date of Death Month February	Day Year 21, 2005 12:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death
			Greater Baltimore Medical Center Towson 5 Social Security Number 6 Sax 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	0.0	Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	Washing DO
			Usual Residence of Decedent	7/10/19	
	anylan show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28e-f show Figurat Le notified at	ecto	Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country?
	3a or	i Dir	24805 Shrubbery Hill Court 20872	108	
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - American Indian,
9	or Ite	y Fu	1 Never Married 2 Married 1	Triodit, etc.,	Black, White, etc. Specify: White it a
5-0036	hour hurel'	ed b	3K Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16	White Sb. Kind of Business/Industry
7.	hin 72	piet	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	ing	Montgomery County
2121	ed with	Сош	2 Administrative Assista		Public Schools
. Pu	htal H	Be	17. Father's Name (First, Middle, Last) Edward Walker Lucinda	e (First, Middle, Ma a Edwards	iden Sumame)
Maryland	shoutd nd Me mark imetic	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		City or Town, State, Zip Code)
	and 2 alth a 27 Is er treu		Thomas E. Robinson/ Son 24805 Shrubbery Hill	Court, Da	amascus, MD 20872
1 & C	of He of He rest		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Febru	Date 20	c. Location - City or Town, State
غ <u>i</u>	timent tent:		'4 Donation 5 Other (Specify) Parklawn MemorialPark	- 1	ckville, Maryland
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygions. Department of Health and Mantal Hygions I in it is marked other then "nature!", or Items 23a or 28e-f show any injury or other freumetic event, it a Ma Jical Erani er in itst be notified at once.		500 University Biva	, W., Sil	ver Spring, MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a shock, or heart failure. List only one cause on each line.	or respiratory arrest	t, Approximate Interval Between Cnset and Death
	Proysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Acute was a final was farchon		4 Days
Son	Examiner		Due to (or as a contequence of):		
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Lifter United Nitro (Cause (Disease or injury)		
2	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
Bebin	cate be executed only sician and the burial-transit		d		
\ cc	tificate ng physias the	Medic	TE SCHOOL STATE OF THE SCH		
Box 6	ath cer ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery Month Day Year
C		Physician/Medical	1 □ Yes 2 □ No 9 □ Unknown 5 □ Other (specify)		World Say (Sa)
<u>a</u>	ss that gned to	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ord	w require been si should		typerteurion	1 ☐ Yes	2 No 3 Probably 4 donknown
Division of Vital Records	ne law has b ge 2 st	Completed	Diabetes mellitus	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
<u></u>	icien: The lav certificate has ector, page 2	a	25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2 ☐	
, ,	Physicien: r this certific ral director.	To B	examiner?		ce 6 Other (Specify)
	ding Pt		1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred
	death death ctor: , y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office	28f. Location (Stree	et and Number or Rural Route Number,
ij	el or A	Certification;	3 Suicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ledicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caus ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month, Day, Year)
	5		Rem E. Thomas MD D60630		2/21/05
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Renu Eliza Se 6701 N. Charles St Suite 3853, Towson, MD 21204	the mon	uus, Mu.
. 1	y Sta		31. Date filed (Month, Day, Year) FEB 2 2 2005 32 Registrar's Signature FEB 2 2 2005		
	Registr	ar	LED NY (100) Denne IL Whenever		

			For State Registrar			of Mary	land / Depa	artment of rtificate of			_	giene	05	07819
	Physici		1. Decedent's Name		,						2. Date of De Month	ath Day	Yeer	3. Time of Death
	/Medic Examir		MARY 4a. Facility Name (In	ANN f not institution	RANTZ n, give street and n	umber)		4b. City, Town,	or Location	of Death	Feb.	18 _{4c} 200	5 y of Death	3:45 A"
			Salisbury							bury,		Wicon	nico	
	Funeral Director		5. Social Security N 219-42-9 Usual Residence of	139	6. Sex 1 ☐ M 2 🛣 F	7. Age (In	yrs. last birthday) 62 Yrs.	If Under 1 Yea Months Days		Min.	3. Date of Bir (Month, Da 3/5/19	th ly, Year) 942	Cou	place (State or Foreign ntry) yland
	nyland how		10a. State	10b. County		100	. City, Town or Lo	ecation						10d. Inside City Limits
	he Ma Ba-f s	Director	MD	Wicom	ico	Sa	lisbury							1⊠Yes 2□No
	with t	DI	10e. Street and Nur 200 Civi		1110			10f. Zip Code 2180				10g. Citizen of	What Cou USA	ntry?
	death	Funeral	11. Marital Status	1110		cedent Ever	in U.S. 13.	Was Decedent of If Yes, specify Cu		igin? (Spec	ify Yes or No	- 14. Ra	ce - Ameri	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Extention of the notified at once.	by Fu	1 X Never Marri 3		ried 1 ∐Yes If Yes, G	2 X No live		1 ⊡Yes 2 🔀 No			can, etc.)	Speci	ick, White,	
8	2 hour	ted b		15. Deceden	t's Education		16a. Dece	dent's Usual Occi	upation			16b. Kind of E	WII.	ite
215	thin 7%	Completed	(Speci		st grade completed College) (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during mos ed)	t of working	7	100.11.10	703111033411	dostry
21	led wil lygien her th nt, the	Con	12				Labor		1			Poultry		
MARY RANTZ Baltimore, Maryland 21215-0036	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Mental Men	o Be	17. Father's Name (ŕ							Maiden Suma	me)	
ary	should be ind Mental marked c	은	John Henri 19a. Informant's Na				19b. Mailir	ng Address (Stree			Taylo		, State, Zip	Code)
RANTZ ore, Ma	and 2 ealth a m 27 is		Glen Rant	tz (Ne	ephew)		5807	George Is	and La					
RA	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disp		3 ☐Removal from	State 20	b. Place of Dispo cemetery, cren	sition (Name of matory or other pl	ace)	Da	te	20c. Location	- City or To	own, State
MARY Saltim	permit. Pag Department Important: any injury c	1	4 □ Donation21. Signature of Full			\$a	lisbury			/19/2		Salisbu		MID
M M	permit. Departr Imports any inju		Mui	had 1	A Dea	n		Name and Addi Holloway 03 Linde	en Ave	., Po	comoke	city,	A. MD 2	1851
	Physician /Medical		23a. Part1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt fallure. List Final	complications that only one cause on Due to		death. Do not ent	er the mode of dy	ring, such as	cardiac or	espiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	eate be executed thysician and the burial-transit	dical Examiner	Sequentially list cor if any, leading to in- cause. Enter Unde Cause (Disease or that initiated events resulting in death) L		b. Due to	Cor as a con	sequence of):	Vo.	reent	an -	de	e o o a		years
Box 6	the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		birth 2 ☐ f nant at time	Fetal death 3	Ectopic pregnand Other (specify)	су				ite of delive	ery Day Year
ords, F	w requires that been signed should be det	by	Part II. Other signifi	icant condition	ons contributing to	death but not	resulting in the ur	nderlying cause g	iven in Part I.			obacco use con ′es 2□No	tribute to th	ne cause of death?
Division of Vital Records, P.O		Completed							-			med?	prior to cor death?	psy findings available mpletion of cause of 2 \(\square\) No
V.	Physician: r this certifica ral director, I	o Be	25. Was case referr examiner?		Hospital	Innationt	2 C C C (0.4	ot no. Ot			Check onl o			
ion of	nding Phy tth. :: After this e funeral d	-	27. Manner of Death 1 Actural 2 Accident		g 28a. Date (Moi	of Injury oth, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Inju	4l+™ui iry at ork?] Yes 2 □ h	28		lence 6 Oth		/)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 4 Homicide	6 Could I	not be ined 28e. Plac build	e of Injury - A ling, etc. (Sp	At home, farm, streed	eet, factory, office		28	Location (S City or Tow	Street and Numb m, State)	er or Rura	l Route Number,
	To the Hospi within 24 hou To the Funer completely fill	Medical	29a. Certifier (Check only one)	1	g Physician: To th Examiner: On the I and mar	e best of my pasis of examiner stated.	knowledge, death nination and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, and th occurred	d due to the o at the time, o	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)
	vith To 1	2	29b. Signature and	title of certifie	1 11			29c. Licen	se number	-	0	29d. Date signe	d (Month, i	Day, Year)
			20 Nor	//V	Ma	7	h 00 \ =		25.	JY	7	4/871	× 5	
C.	H. H		30. Name and addre	OBINS,	M.D. 2	00 CIV	IC AVE.		RY, MD	. 21	804			
	Sta Registr	te ar	31. Date filed (Mont	FEB 2	2 2005 32.	gistrar's Si	ignature	nedi						

Plea

ise Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene	0.7
Contisionts of Double	11/

S			1 - State Registrar	Ce	rtificate of Death	Reg. i	2005 0/820	
П	Physici	án	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day_ Year 3. Time of Death	_
	/Medic		John	Richardson		February	18, 2005 1755 p [™]	
	Examin	er	4a. Facility Name (If not institution, give stre 2100 N. Anvil Lane	et and number)	4b. City, Town, or Location of Death Temple Hills	1	4c. County of Death Prince Georges	
	Funeral Director		5. Social Security Number 6. Sex 1\(\overline{\overline{\Omega}}\) 6. Sex 1\(\overline{\overline{\Omega}}\) 6. Sex	7. Age (In yrs. last birthday) 2 F Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea April 27	9 Birtholace /State or Foreign	7
	D		Usual Residence of Decedent			ipiti o,		
	anylar show	اۃا	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits X ☐ Yes 2 ☐ No	
	the M 28a-f	Director	Md. P.G.	Temple	10f. Zip Code	100	Citizen of What Country?	_
	ath with	rai Dir	2100 North Anvil		20748	Un	nited States	
36	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-1 show he Madical Examiner must be notified at	y Funerai	11. Marital Status 12. Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 No If Yes, Give	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
9	2 hour	Completed by	15. Decedent's Educati	Year or Dates: on 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Industry	
212	hin 72 9. M. di	plet	(Specify only highest grade co	ompleted) (Give	kind of work done during most of workin DO NOT use retired)	g	Third of Businessamoustry	
7	filled wit Hygiene other tha	Con	12		Manager		Safeway	
Maryland 21215-0036	2 should be fill and Mental Hy is marked oth reumatic even	To Be	17. Father's Name (First, Middle, Last) Philip Antho:	ny	18. Mother's Name Renee C	(First, Middle, Maid Larter	en Sumame)	
	요두다루		19a. Informant's Name/Relationship (<i>Type</i> , Renee Richardson	/mother 19b. Maili Mash	ng Address (Street and Number or Rural Randolph St nington, DC 200	Route Number, City N E . 18	y or Town, State, Zip Code)	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		20a. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	osition (Name of Damatory or other place)	20c.	Location - City or Town, State shington, DC	
Balti	permit. DepartmImporte any inju		21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility Hod	_	dwards F.H. itland, Md.20746	
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ons that caused the death. Do not en			Approximate Interval Between	
	Physician :	į d	Immediate Cause (Final disease or condition	MENINGITIS			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				-
	Examine:	Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of);				_
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Siscass or injury that initiated events	= 20 10 (01 20 20 10 10 10 10 10 10 10 10 10 10 10 10 10				
o,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a consequence of):				-
68760,	cate b	Medical	d					_
×	certific Iding p		IF FEMALE: 23c.	If yes, outcome of pregnancy			Old Date of delivery	
.O. Bo	The law requires that the death ce tte has been signed by the attendi bage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
<u>α</u>	es that igned b	y Pt	Part II. Other significant conditions contrib	uting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?	
ğ	w require been sig should b	ted t				1 ☐ Yes	2 No 3 Probably 4 Unknown	
Division of Vital Records,	The law r te has be rage 2 sh	Completed by				24a. Was an autopsy performed?		
ita	ysicien: The lis certificate hadirector, page	Bec	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		-
d		မ	Y∑ Yes 2 No Host	I □ Inpatient 2 □ EH/Outpatier	nt 3 DOA Other: 4 Nursing Hom	e 5 Residence	6 Dother (Specify) at scene	
OU	ding h. After funer	tion	1 atural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	f 28c. Injury at 28 Work? M 1 □ Yes 2 □ No	3d. Describe how inj	jury occurred	
Visi	or Attencater death Director: in by the	Certification;	3 Could not be	8e. Place of Injury - At home, farm, str		3f. Location (Street:	and Number or Rural Route Number,	-
Ö	d in		4 C COURSIDE	building, etc. (Specify)		City or Town, Sta	ne)	
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner:	an: To the best of my knowledge, deatl On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, are vestigation, in my opinion, death occurred	nd due to the cause(d at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	(N	29c. License number		Date signed (Month, Day, Year)	_
	Ta		Moline Me	Kull Im	OCME	F	'ebruary 19, 2005	
_	(1)		30. Name and address of person who comp	leted cause of death (Item 23a) (Type, KOREW		D-1.	M 4 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature	TIT LEIN PLLEET	Baltimo	ore, Maryland 21201	_
	Registr		FEB 2 3 2005	Alden & April	W S			

Second Security Number Accounty of Death	D de City Limits Yes 2 No
Particular JAMES EWING STAYTON February 23,2005 Macroad Land	ate or Foreign D de City Limits Yes 2 □ No
Second Security Number Second S	D de City Limits Yes 2 No
S. Social Security Number 6. Sex 7. Aga (in yrs. last birthday) 1 Under 1 Year 1 Under 2 Hrs. 6. Det of Birth (Morth) 214-28-3280 18 M 2 F 7.3 yrs. 100. City, Town or Location 100. List steed and Number 100. City, Town or Location 100. List steed and Number 100. City, Town or Location 100. List steed and Number 100. Street and Number 360 ST. AUBINS TERRACE 21601 USA 11. Markal Status 1 Mover Married 28 Married 10. Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Morth of December 1 M	D de City Limits Yes 2 No
USUAL Residence of Decedent 108. State 109. County TALBOT	de City Limits Yes 2 □ No
TALBOT 10a. State 10b. County 10c. City, Town or Location 10d. Institute 10d. In	Yes 2 No
GEORGE W. SIXITON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location · City or Town, State, Zip Code) 20d. Method of Disposition 1	an,
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23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	ND
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Immediate Cause (Final disease or condition resulting in death) Medical Examiner Immediate Cause (Final disease or condition resulting in death)	ximate al Between and Death
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	days
Sequentially list controllations and if any, leading to immediate Due to (or as a consequence of):	
that initiated events resulting in death) Last	
be de de de de de de de de de de de de de	
Single August 11 11 11 11 11 11 11 11 11 11 11 11 11	
9 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
in the past 12 months? 1 Yes 2 No 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)	Year
Q et la dela de	e of death?
So to to to to to to to to to to to to to	4 Unknown
24a. Was an autopsy performed? Act The Act Ac	
autopsy performed? The completion of the comp	5
25. Was case referred to medical examiner? 1	
25. Was case referred to medical examiner? 1 Yes 2 No No period 1 Yes 2 No No period 26. Place of Death Check onlone 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of Injury 28b. Time of Injury at Work? 1 Yes 2 No No period 28c. Injury at Work? M 1 Yes 2 No No period 28d. Describe how injury occurred	
28a. Date of Injury Work? 1	Number,
A Lo to the control of the control o	
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	
e to the signed (Month, Day, You and manner states. 29c. License number 29d. Date signed (Month, Day, You are si	use(s)
Sully (/5 (huttom) D31466 2/25/05	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUDWIG J. EGESEDER III M.D. 503 IDLEWILD AVE., EASTON, MD 21601	
State Registrar 31. Date filed (Month, Day Year) FEB 2 5 2005	

DHMH 17 Rev 1/2001

ORIGINAL

	For State Registrar	State of Marylan	o / Department o Certificate	of Health and N Of Death	nentai Hygiei Reg.		07822	
Physician	1. Decedent's Name (First, Middle, James Meade S	·			2. Date of Death Month Feb. 17		3. Time of Death 5:24 p M	
/Medical - Examiner	4a. Facility Name (If not institution,		4c. County of Death					
LXammer	207 Belvedere	Avenue		Cambridge		Dorches	ster	
Funeral	5. Social Security Number 6	9. Bir	thplace (State or Foreign					
Director	214-32-7477	107M 2□ F 9		ays Hours Min.	8. Date of Birth (Month, Day, Ye May 10,		Maryland	
1 -	Usual Residence of Decedent 10a, State 10b, County	10c. Cit	v. Town or Location				10d. Inside City Limits	
Imporant: It iam 27 is marked other than include, or reins 239 or 239-1 show any injury or other treumetic event. The Medical Examinat must be notified at once. To Be Completed by Funeral Director	Maryland Dorch	ester	Cambrio	doe			1 Yes 2 No	
lec le	10e. Street and Number	CBCCI	10f. Zip Co	()	10g.	Citizen of What C	ountry?	
in Die	207 Belvedere	Avenue		21613		USA		
Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race · Am		
교	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2 ☐		rican, etc.)	Black, Whi	te, etc.	
d by	3 Widowed 4 □ Divorced	Year or Dates:			12.7	V	White	
Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Decedent's Usual O (Give kind of work of life DO NOT use to	ccupation one during most of work etired)	sing 16b	. Kind of Business	/Industry	
E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Grocer	3.1100)		Grocer	•17	
Be C	17. Father's Name (First, Middle, La	st)	020002	18. Mother's Nam	e (First, Middle, Maid		. <u>y</u>	
10 B	William H. Si	mmons		Matild	a Tyler			
	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (St	reet and Number or Rur	al Route Number, Ci	ty or Town, State,	Zip Code)	
	Deborah J. Jone	s, Daughter	157 East Ma	ain St., El	kton, MD	21921		
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		lace of Disposition (Name of emetery, crematory or other	of place)	Date 20c	. Location - City or	Town, State	
	`4 □Donation 5 □ Other (Spe	cify) Ho	sierMemorial(ChurchCem.	2/20/05 Fi	ishin Cr	eek. MD	
ouce.	21. Signature of Funeral Service Lie						20	
OI .	(Malled ttr	rin- famille	ACC 308 Hich	St., Camb	ridge, MD	21613		
	21. Signature of Funeral Service City 21a. hart Enter the disease, or shock, or heart failure.	ripications that caused the death	i. Do not enter the mode of	dying, such as cardiac	or restratory arrest,		Approximate Interval Between Onset and Death	
ian ical	Immediate Cause (Final disease or condition resulting in death)	u	roscle roti	" heart	disease			
ner		Due to (or as a consequ	uence of):					
edical Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence)	uence ot _j :					
Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions of the condition							
Ä	resulting in death) Last	Due to (or as a conseq	uence of):					
dicai		d						
	IF FEMALE:	220 If you outcome of program	nav					
Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnate 1 Live birth 2 Feta 4 Pregnant at time of details.	death 3 Ectopic pregn			23d. Date of de Month	livery Day Year	
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	aun 5 □ Other (specii	y)				
by Pr	Part II. Other significant condition	s contributing to death but not res	ulting in the underlying caus	e given in Part I.	23e. Did tobaco	co use contribute to	o the cause of death?	
Q D					1 🗆 Yes	2 □ No 3 □ P	robably 4 DUnknown	
Completed by P					24a. Was an	24b. Were a	utopsy findings available	
lion; To Be Com					autopsy performed 1 ☐ Yes 2 ☑	? death?	completion of cause of	
0	25. Was case referred to medical			26. Place of Deat	h (Check only one)	70 1016	20110	
ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	Other: 4 Nursing Ho	ome 5 Desidence	6 ☐Other (Spe	ecify)	
no.	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury	Injury at Work?	28d. Describe how in	njury occurred		
Certification:	2 Accident investiga 3 Suicide 6 Could no	t ho	М	1 ☐ Yes 2 ☐ No				
Ē	4 Homicide determin	building, etc. (Specify	ome, farm, street, factory, of	fice	28f. Location (Street City or Town, St		ural Route Number,	
	29a. Certifier 1 Certifying	Physician: To the best of my kno	wledge, death occurred at ti	ne time, date and place	and due to the cause	o(c) and manner a	s stated	
	(Check only 2 Medical Ex	aminer: On the basis of examina and manner stated.	tion and/or investigation, in	my opinion, death occur	red at the time, date	and place, and due	e to the cause(s)	
dical	one)		20	cense number	204			
Medical	one) 29b. Signature and title of certifier	MILAN	29c. Li	561139 [1611156]	290.	Date signed (Moni	th, Day, Year)	
Medical	one)	My De	111	66659		Date signed (Moni		
completely filled in by the	one)	mo completed use of death (Item	D5	6659	Fe	bruary 1	8, 2005	

			1 - For Amend Item State Registrar	24State	of War	yland 42er Ce	arments de la la la la la la la la la la la la la	gaith a Death	nd Mental H	ygienje () Reg. No.	05	07823
	Physici	an	DORIS	•	IACK				2. Date of D Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City, Town, or	Location of	FEB.	22, 4c. Co	2005 unty of Death	0345 M
ı	Exami		6616 Baileys	Store	Road	i	Feder				chest	
	Funeral Director		213 44 0133	ex □M 2DKF	7. Age ((In yrs. last birthday 60 yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Dete of B NOV. 2	irth (av. Year) 1,194	9. Birth Cou Mar	place (State or Foreign ntry) yland
	and w.		Usual Residence of Decedent 10a. State 10b. County		1	Oc. City, Town or L	ocation					10d. Inside City Limits
	Many P-f sho	tor	MD Dorch	ester		I	ederals	burg				1 ☐ Yes 2 🖾 No
	or 28c	Director	10e. Street and Number	-			10f. Zip Code			10g. Citizer	of What Cou	ntry?
	s 23a	ral	6616 Baileys					1632			ed St	
36	d within 72 hours after death with the Maryland jiene. r than "naturel", or items 23s or 28e-f show It e Madical Exertinet must be natified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Ŵidowed 4 □ Divorced	12. Was De Armed F 1 Tyes If Yes, G Year or	orces? 2 No	er in U.S.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐XNo	ispanic Orig n, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		Race - Ameri Black, White, ecify: B	
215-003	72 hou natura	ted t	15. Decedent's E	ducation		16a. Dec	edent's Usual Occupa	ation		16b. Kind	of Business/In	
2121	d within 7 giene. rr than °n Ir e Mad	Completed	(Specify only highest grade) Elementary/Secondary (0-12)		(1-4or 5+)	life.	e kind of work done of DO NOT use retired ified Nurs)	9	Nurs	ing H	ome Care
	be filed ital Hygi of other	Be	17. Father's Name (First, Middle, Last,						's Name (First, Middl			
Maryland	should be nd Menta marked umatic ev	٩	Emerson L. Eva			405 14-1			h Irene			
<u>8</u>	s 1 and 2 should Health and Meritam 27 is marks other traumatic		Jeffrey L. Eva		n	661	6 Bailey	na number 7 s St	or Rural Route Number ore Rd.,	per, City or To Fede	wn, State, Zir ralsh	urg. MD
Je,	of Healitam		20a. Method of Disposition			20b. Place of Disp			Date		ion - City or To	
altimore,	Pages ment of ant: If it ury or o		14 Burial 2 Cremation 3 € '4 Donation 5 Other (Specif		1 State	Federa	1 Hill (Cem	2/28/05		ralsb	
Ball	permit. Pages Department of important: If it eny injury or o once.		21. Signature of Funeral Service Licer	M.	da	le 2	2. Name and Addres	s of Facility	Framptom t., Fede	Fune ralsb	ral H	ome, P.A. MD 21632
V.			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that one cause on	caused the	e death. Do not er	iter the mode of dying	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	orasa o	consequence of):	16/10-	40	promo			1 year
6	Examiner		Sequentially list conditions,	b								
	ted nsit	nlner	cause. Enter Underlying Cause (Disease or injury	Due to	for as a	consequence of):						
,	execu in and ial-tra	Examin	that initiated events resulting in death) Last	c. Due to	(or as a o	consequence of):						
8760,	ficate be executed physician and s the burial-transit	dlcal		d								
9			IF FEMALE:	220 If you or	stoom of	0.0000000000000000000000000000000000000		340 A				_
O. Box	at the death certific by the attending prached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 nant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ery Day Year
1	ires that the signed by detact		Part II. Other significant conditions of	ontributing to	death but	not resulting in the	underlying cause give	n in Part I.	23e. Did	tobacco use	contribute to the	ne cause of death?
rds,	law requires that the as been signed by th 2 should be detache	ed by	NON13Chemic	Ce.	1 di	omo	rethy.		1□	Yes 2	o 3 🗆 Prob	ably 4 Unknown
ecord	law requiras been 2 should	Completed	Diabetes	Mel	lofe	, ,			24a. Was		4b. Were auto	psy findings available mpletion of cause of
E E	: The lav cate has page 2:	Con							perf 1 ☐ Yes	ormed? 2⊠No	death?	
Vita	Physician: Tribis certifical ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:			Cthe		of Death (Check only			
o	g Phys er this eral di	Η,	27. Manner of Death	28a. Date	Inpatient of Injury	28b. Time o	of 28c. Injury	at	sing Home Res 28d. Describe			/)
ion	ending F eath. or: After he funer	atlo	1 Natural 5 Pending investigation	1	nth, Day Y	(ear) Injury	M 1 🗆 Y	:? ′es 2 □ N	0			
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not b 4 Homicide determined	289. Plac	e of Injury ding, etc. (- At home, farm, st (Specify)	reet, factory, office		28f. Location City or To	(Street and Ni wn, State)	umber or Rura	l Route Number,
	na Hospil n 24 hour na Funar	Medical	29a. Certifier (Check only one) 2 Medical Example 1	niner: On the	e best of r basis of ex nner state	camination and/or in	th occurred at the time evestigation, in my op	e, date and inion, death	place, and due to the occurred at the time	cause(s) and date and pla	manner as si ce, and due to	ated. the cause(s)
	To the To the comp	Σ	29b. Signature and title of sectifier	200		/	29c. License		2.4.1		gned (Month,	
			· UX	///			(10)	039	4/	2/2	2/20	105
			30. Name and address of person who	Simpleted cau	se of deal	th (Item 23a) (Type	Print) Poda	len	Rd Bri	duev	1/0 1	7519537
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's	Signature	11 Inches		0,7	77	- / -	-11/0
	Registr	ar	LED % 3 7	JUD /	Salves	S 13 1	2003					

DHMH 17 Rev 1/2001

	Registrar 1. Decedent's Name (First, Middle, Last)		rtificate of	Dealii		2. Date of D	Reg. No eath	3 0 0	3. Time of Death
ician dical	Deane Sherman					Month Feb.		2005	2:50 P
niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location o	of Death	100.		Death		
	11016 Ardwick Drive		Rockvill		_			Montg	omery
al or	5. Social Security Number 220-34-4239 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of B	TY 191	9. B	Birthplace (State or Fore Country) eulah, ND
	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Lo	cation						10d. Inside City Lim
to	MD Montgomery Rock	kvill	e						1 □XYes 2 □ i
once. To Be Completed by Funeral Director	10e. Street and Number		10f. Zip Code				10g. Ci	Citizen of What Country?	
ral	11016 Ardwick Drive		20852				ates		
by Funeral Director	11. Marital Status 1 Never Married		Was Decedent of H fYes, specify Cuba 1 ☐ Yes 21,7 No	ispanic Ori in, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	10-	Black, V Specify:	American Indian, White, etc.
ted	15. Decedent's Education	16a. Deced	dent's Usual Occupa	ation			16b. K	and of Busin	White ess/Industry
ompleted	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done on NOT use retired	during mos ()	t of work	ing			,
Com	3+	Volu	nteer				Mus	sic An	d_Arts
Be (17. Father's Name (First, Middle, Last)					(First, Middl		Sumame)	
2	Charles B. Murray					Mille			
	19a. Informant's Name/Relationship (Type, Print) Dr. John Sherman / Husband		g Address (Street a						
	20a. Method of Disposition 20b. Plac	e of Dispo	sition (Name of			Date	-		y or Town, State
>	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cem	etery, crer	natory or other plac	1		-			
	21. Signature of Funeral Service Licensee	COMI	ort Crema	s of Facilit	02/2 v -	1/2005	ALEX	andri	a, vA
	M01378	51	Name and Addres	ısin A	Jose lve.	eph Gav	viers Wash	Sons	, inc.
Jer.	23a. f ant 1. Enter the sease of conflictations that caused the death. I shock, or her failure. Ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Listense or injuly that initiated events.	ympho nce of):		3 , 0 3 0 1					Approximate Interval Between Onset and Death 8 Years
edical Examine	Cause Chief of India y that influence that influenc	ace of):							
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Yes 2 No 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)					23d. Date of Month	delivery Day Year
d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute in Cardiomyopathy, Chemotherapy induced								
ompleted by						24a. Wa	s an	24b. Were	autopsy findings availab to completion of cause of
Con							ormed? 2X No	deat	h?
Be	25. Was case referred to medical examiner?		04			(Check only			
<u>ا</u>		Outpatien b. Time of	3 DOA	ar: 4 □ Nu		ne 🌠 Res			Specify)
ton	1 X Natural 5 □ Pending (Month, Day Year)	Injury	28c. Injury Work	al (? (es 2 □ N		28d. Describe	now injui	y occurred	
Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home	, farm, stre			-				r Rural Route Number,
ert	4 Homicide Getermined building, etc. (Specify)		•			City or To	wn, State)	
edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and pinion, deat	d place, a	and due to the ad at the time	cause(s) , date and	and manner d place, and	r as stated. due to the cause(s)
Me	29b. Signature and title of certifier		29c. License	number			29d. Dat	te signed (M	onth, Day, Year)
	Ileena L. Shapir		D3533	16			Feb.	17, 2	2005
	30. Name and address of person who completed cause of death (Item 23	la) (Type, l	Print)						
	Deena J. Shapiro, MD / 10810 Conne 31. Date filed (Month, Day, Year) FEB 2 2 2005			Kensi	ingto	on, MD	208	95	

Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland		nt of Health and te of Death		giefe () ()	5 07825)
	Physicia	200	1. Decedent's Name (First, Middle, Las	,	2		2. Date of Dea Month	ath Day	3. Time of Death	1
	/Medic			SHANK SK			February		2005 12:22 P	М
	Examin	er	4a. Facility Name (If not institution, give	e street and number)	4b. Cit	, Town, or Location of Deat	h	4c. County	of Death	
			201 Baker Hill 5. Social Security Number 6. S			Williamsport er 1 Year If Under 24 Hrs			Washington	
	Funeral Director			ex 7. Age (In yrs. II	Yrs. Month		8. Date of Birth (Month, Day	n y. Year)	Birthplace (State or Fore Country)	ign
		-	Usual Residence of Decedent				July JI,	1921	Maryland	
	yland		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limi	its
	e Ma	cto	Maryland Washi	ngton	Willia	msport			1 X Yes 2 □ N	Vo
	ih th	Director	10e. Street and Number		10f. Z	ip Code		10g. Citizen of V	Vhat Country?	
	ath w	<u>ra</u>	201 Baker Hill	ane Apt. 1		21795			USA	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	If Yes, so	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.	
36	rs aft	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No 1952 If Yes, Give Year or Dates: 1952	. 1 ☐ Yes	XXNo Specify:		Specify	: \ull= : + -	
21215-0036	72 hours after death with the Maryland natural; or liens 23a or 28e-f show Jical Examinet cust be motified at	ed	15. Decedent's Ed	Jucation	16a. Decedent's Us	ual Occupation		16b. Kind of Bu	White	
215	7 nin 72	plet	(Specify only highest gra	College (1-4or 5+)	(Give kind of v life. DO NOT	ork done during most of wo	rking	700.71.110 0, 20	on obamoustry	
212	d with	Completed	7	College (1-401 5+)	La	yout		Sheet Met	al Fabrication	
	al Hy al Hy I othe	Be	17. Father's Name (First, Middle, Last)	-		18. Mother's Na	me (First, Middle,	Maiden Sumam	θ)	
yla	2 should be filed within 72 hours after death wished Mental Hygiene. Is marked other than "natural", or items 23a rametic event, the Medical Examination of the file Medical Examination of the Medical Examinatio	2	Earl Clifford S	nank			Irene Da			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or liems 23a or 28e-1 show it item 27 is marked other than "natural", or liems 20a or 28e-1 show or other traumetic event, the Marical Examinar court by colline and		19a. Informant's Name/Relationship (ss (Street and Number or Ri				
	l and lealth im 27 her ti		Shirley A. Shanl 20a. Method of Disposition			r Hill Ln. Ap	1179			
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tra once.		1 🖁 Burial 2 □ Cremation 3 □	Removal from State	lace of Disposition (Nemetery, crematory or	other place)	Date	20c. Location -	City or Town, State	
Ħπ	permit. Page Department Importent: If any injury or once.		'4. □Donation 5 □ Other (Specif	131 66	enlawn_Mem	. Park Feb.2	26.2005 W	Illiams	port, Marylan	d
Bal	Department of the partment of		21. Signature of Funeral F rvio Licor	IS 8 8		ne ^a ttineFally Ho				
			23a Part 1 Enter the disease or com	nlications that caused the death	425 S	. Conococheac	ue St. W	illiams	port, MD 21795 Approximate	
	Physician		23a. 241. Enter the disease, or com- lock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line. Polycyt		era	or respiratory an	rest,	Interval Between Onset and Death	1.0
1	/Medical		resulting in death)	a Due to (or as a consequ					1 monc	12
	Examiner		Sequentially list conditions	b						
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequ	uence of):					
	death certificate be executed e attending physician and of for use as the burial-transit	хаш	that initiated events resulting in death) Last	c Due to (or as a consequ	ioneo of):					
8760,	eath certificate be exattending physician for use as the buria	al E		oue to (or as a consequ	derice or).					
387	phys the	dlcal		d						
9 X	certif ding	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnar	ncv		77	224 Day		
Box	atter i for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			Mor	e of delivery hth Day Year	
O.	that the death ed by the atte detached for	nys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
σ.	requires that the een signed by th nould be detache	y PI	Part II. Other significant conditions of		ulting in the underlying	cause given in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?	
rds	w require been sig should b	ed b	Diabetes Mel	litus			1 □ Y	es 2 A No	3 ☐ Probably 4 ☐Unknov	ΝΠ
Records,	> 0 0	Completed by	Chronic obstru	ctive pulmon	ary disea	se	24a. Was a	an 24b. V	Vere autopsy findings availab	ole ole
R	o = o	E	Chronic renal	<u> </u>			autop: perfor 1 Yes	med? d	rior to completion of cause o eath? □ Yes 2□ No	ıt
Vital	yalclan: Th is certificate director, pag	Bec	25. Was case referred to medical	7012011		26. Place of Dea	ath (Check only or		2 100	_
of V	d is	10	examiner? 1 □ Yes2 💆 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 0	Other: 4 Nursing H	lome 5 🕱 Resid	ence 6 Othe	er (Specify)	
0	ding Ph The After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurre	∍d	
sio	Attending I er death. rector: After by the funer	catl	2 Accident investigation		М	1 ☐ Yes 2 ☐ No				
Division	or Att	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (S City or Tow	treet and Numbern, State)	er or Rural Route Number,	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		200 Contine + TO - Miles	uniniam. Ta the beat of	uladas 1 ii		<u> </u>			
	24 hc Fun	edical	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 ★ Medical Exar	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wiedge, death occurre tion and/or investigation	a at the time, date and place n, in my opinion, death occu	e, and due to the d irred at the time, o	ause(s) and mar date and place, a	nner as stated. Ind due to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and marrier states.	2	9c. License number	2	29d. Date signed	(Month, Day, Year)	
	p= ≤ == Ö		Dad W.	1 22 22 410		D 65572		_		
		i	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	9 43763		00.4017	23, 2003	-
8	H-4+1	1	30. Name and address of person who Rodu M. Theodox: 31. Date filed (Month pay, Year)	completed cause of death (Item	23a) (Type, Print) T Antietam	Street Suite	203 Ha	gerstown	23, 2005 Maryland 211	740

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year February DORIS **JANE** SMITH 1045 PM 22 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WASHINGTON COUNTY HOSPITAL HAGERSTOWN
If Under 1 Year If Under 24 Hrs. WASHINGTON Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Days Yrs. Director 219-44-4676 26. 76 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 le marked other than "naturel", or Items 23e or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "naturel", or Items 23e or 28a-1 show other traumatic event, the Medical Examinar must be redified at 1 X Yes 2 ☐ No Director MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 DELLA LANE 21713 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER AUTOMOBILE DEALERSHIP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES FREDERICK CROWL GOLDIE M. BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GENE W. SMITH/SPOUSE 205 DELLA LANE, BOONSBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BOONSBORO CEMETERY 2/25/2005 BOONSBORO, MARYLAND 21. Signature of F Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery ed by the attended for us 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not restring in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2010 1 Inpatient Certification: To this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner ef Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Anatural 5 Pendina investigation 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature ar 29d. Date signed (Month, Day, Year) d title o 00022043 PHAGERSTAUN MD 31. Date filed (Month-Pay 32. Registrar's Signature State Registrar Toute

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 19, Elizabeth Swann February 2005 1:46 P Vera 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/24/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 M 2 X F 577-56-3848 86 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🗵 No Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9501 Badger Avenue 20735 USA Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXVo Specify: **Black** 3 X Vidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7th Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nellie Ann Proctor Martin Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethelreda Swann / Daughter 9501 Badger Avenue Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/23/05 Kalas Crematory * 4 □ Donation 5 □ Other (Specify) Edgewater, Maryland 22. Name and Address Facility ge P. Kalas Funeral Home PA 6160 Oxon Hill Coad Oxon Hill, Varyland 20745 21. Signature & Funeral Service Licensee a 23a. Part 1. Both rithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) seve Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

D46478

29d. Date signed (Month, Day, Year)

2-20-05

Surretts Rd. Clinton mD20731

Examiner or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transil Division of Vital Records, P.O. Box 68760, the been signed b page 2 s After death. within 24 hours after death To the Funerel Director: in by t To the Hospitel

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature and title of certifier

Funeral

Director

th and Mental Hygiene. 7 is marked other then "natural", or items 23s or 28s-f show traumatic event, the Medical Examinating the notified at

permit. Pages 1 and 2 s Department of Heatih ar Important: if item 27 is any injury or other trau

Physician

/Medical

Peges 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) FEB 2. 3 2005

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

		1 - For State Registrar	State of Maryl		artment of rtificate of		Mental Hy	/giene	5 07828
Physicia	_	Decedent's Name (First, Middle, Last) Mary Magdelene S			· · · · · ·		2. Date of D Month Febru	Day	Year 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give a			4b. City, Town	, or Location of Death		4c. County o	
	•	Union Huspital		ounty	Elk	L Tow ar If Under 24 Hrs.	Ta 2 : 42	Cec	il
Funeral Director		5. Social Security Number 6. Sep 226-36-6778 Usual Residence of Decedent	111 000 0	74 Yrs.	Months Day		8. Date of B (Month, D July 1	1,1930	Birthplace (State or Foreigr Country) Virginia
5-0036 72 hours after death with the Maryland natural', or Items 23a or 28a-f show deal Examiner must be notified at	_	10a. State 10b. County		City, Town or Lo	ocation				10d. Inside City Limits
the Ma	Funeral Director	Delaware New C	astle		New Ca			10g. Citizen of W	1 Yes 2 No
3a or					1972			B. III A	
death ms 2	nera	5 Don Ave. 11. Marital Status	12. Was Decedent Ever i	n U.S. 13.		f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or N	United :	- American Indian,
nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If Itam 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at	by Ful	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give	į	n⊺ Yes, specnry Cu 1 □ Yes 2 52 N		Hican, etc.)	Specify:	, White, etc.
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d 212 filed withi Hygiene. other then	Com	12	00110g0 (1-401 3+)		Homemak	cer		Own Ho	ome
be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	e, Maiden Sumame)
Maryland d 2 should be fill th and Mental H ? Is marked out traumatic even	၉	James P. Thompson		405-14-16			Neta Ne		
and 2 sho salth and n 27 is my iar trauma		B. Allen Maxey /	•			et and Number or Rui			- 83
Baltimore, M permit. Pages 1 and 3 Department of Health Important: if item 27 any njury or other tra		20a. Method of Disposition	20	b. Place of Dispo			Date NOIL		City or Town, State
altimore		1 I Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			netery Feb.	19,200	5 Port	Penn, DE
Balt permit Depart Import		21. Signature of Funeral Service License	\rightarrow	Sp.	Name and Add	ress of Facility LLIKIN Fun	eral Ho	mes, Inc	•
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Physician /Medical		disease or condition resulting in death)	Due to (or as a con	sequence of):	cretor	7 tolo	Inc		dy horis
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be sit	iner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sectiones of):	1	(2 1
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cord we require s been sl	Completed	1	/ • •				24a. Was		ere autopsy findings available
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Division of Vita With the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edicai (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death unation and/or in	n occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
To the within To the complex	Me	29b. Signature and title of certifier	7			nse number		29d. Date signed (
		> all aghi	Jun -		000	55190		February	22, 2005
10		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print)				21,2005
10		Uncon Hospital 31. Date filed (Month, Day, Year)	of Cecil 32. Registrar's Si	County	106 0	sow St, E	IKtou	MO	2192/
Sta Registra		FEB 2 3 2005	32. Registrars Si						-

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	show	_	10a. State	10b. County		100	c. City, Town or L					10d. Inside City Limits 1 □XYes 2 □ No
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93	ral', c	d by	3 Widowed 4	Divorced	Year or I	Dates: WV	V II	1 ☐ Yes 2 📉 No	Specify:		Speci	white
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of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent resulting in death) La IF FEMALE: 23b. Was decedent resulting in the past 12 m 1 Yes 2 yes	pregnant nonths? No cant condition and to medical condition 5 Pendir investin 6 Could determ 1 Certifyir 2 Medical itle of certifion ass of person	Due to d. 23c. If yes, or 1 Live 4 Pres 9 Unkil Dons contributing to the second or 1 Pres 28a. Date (Mo. 1 Pres 28a. Date (Mo. 28e. Plac build and Physician: To the Examiner: On the and ma who completed car See Plac 1 Pres 2 Plac 2 Plac 2 Plac 3 2 2 Plac 3 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	utcome of p birth 2 man at a time nown death but nown death but nown death but nown, Day Years of Injury and page of Injury ding, etc. (Some best of me basis of examiner stated.)	regnancy Fetal death	ont 3 DOA Other (specify)	26. Place of Deaner: 4 Nursing Hry at rk? Yes 2 No	24a. Was auto perful 1 Yes th (Check only ome 5 Res 28d. Describe 28f. Location (City or To	tobacco use cor Yes 2 No San Psy Psy Psy Psy Psy Psy Psy Psy Psy Psy	ntribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ther (Specify) urred her or Rural Route Number,
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		ŀ	1- For Unpend Item 23a,27,28a-1 per me C341 3-24-05 tas Registrar Certificate of Death	lental Hygie Reg.	2005 07830
П	Physicia	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year 3. Time of Death
	/Medic	al	Jailyne Dewayne Tull	February	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death North Arundel Hospital Glen Burnie		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arundel 9. Birthplace (State or Foreign
	Director		216-71-6606 150 20F Yrs. Months Days Hours Min.	Dec. 23	2004 Maryland
	and *		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryli f sho	ō	Maryland Anne Arundel Millersville		1 ☐ Yes 2 ŽNo
	28e-	Directo	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	h with	al D	625 Crucible Court 21108		J.S.A
	within 72 hours after death with the Maryland ene. than *natural', or items 23e or 28e-f show to Madical Exemples maist be multied at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - American Indian, Black, White, etc.
36	s afte	y Fu	1 Never Married 2 Married 1 Yes 2 No Specify:	, many etc.,	Specify:
21215-0036	hour	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation	166	Black D. Kind of Business/Industry
75	nin 72 In *ne	plet	(Specify only highest grade completed) (Give kind of work done during most of workii Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of workii life. DO NOT use retired)	ing	o. Kind of Business/maustry
7	d with	Com	College (1-401 34)		
Maryland	be file d oth	Be		(First, Middle, Mai	den Sumame)
걸	a Men narke natic	2		Church	
Ma	d 2 si th and t7 is r treur				
	tem 2		20a. Mathod of Disposition 20b. Place of Disposition (Name of	Date 200	LOCATION - City or Town, State
E O	Pages ent of nt: If i		1 Magurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem.Garden	2/26/05 H	Mebron, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28e-1 show any injury or other treumatic event, It a Modical Examinat must be notified at ones.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral	Homo	.ozzonyna.
<u> </u>	89 58		Madys B. Slewart 821 West Rd. Sali	isbury, M	id.21801
	₩ 🕏		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart foliume. List only one cause on each time.	or respiratory arrest,	Approximate the threat Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Sudden Unexplained Death in Infancy		Onset and Death
	Examiner		Due to (or as a consequence of):		
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	cuted nd ransit	Examiner	cause Enter Underlyin Cause (Disease or Injury that initiated events c		
ő,	e exe	EX	resulting in death) Last Due to (or as a consequence of):		
68760,	ficate be executed physician and s the burial-transit	edical	d		
_	eath certifi attending for use as		IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of delivery
Box	death certii e attending id for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
P.0.		hys	9 ☐ Unknown		
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ord	w requir been si should			1 Tes	2 No 3 Probably 4 Unknown
Vital Records,	has b	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
alF	The ese			1 Yes 2□	
Z	siclar certif	Be c	25. Was case referred to medical examiner? 26. Place of Death Place of Death Place of Death 1		
ō	Phy er this	1; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	me 5 ☐ Residence 28d. Describe how i	e 6 □Other (Specify) injury occurred unk
ion	Attending Physician: or death. ector: After this certifically the funeral director.	atlo	2 Accident Investigation Found, M 1 Yes 2 No		dik
Division	l or Attencatter death Director:	Certification:	3 Suicide 4 Homicide A Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate) 625 Crucible Ct.,
	urs after or reel Director		round in residence	nttersvil	Lie, MD
	To the Hospitel or Attending i within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a configuration of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Dey, Year)
			OCME OCME		bruary 23, 2005
	H \$ H 0				Diuary 23, 2003
	H \$ H 0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		,
	H S H O		CAROL H Allan und 111 Penn Street		ore, Maryland 21201
	Sta Registr		712 D C.		,

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Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show any njury or other traumatic avent, it is Modical Examination to intering an angel.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	For State of Maryland / Depart State Registrar State of Maryland / Depart Certifi	ment of Health and ficate of Death		ene 0 0	05 07831
	Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
1	Edward C. Thomas		Month 2	/17/05	04:56 A
r		o. City, Town, or Location of De	eath	4c. County o	
	Chester River Hospital	Chestertown	1	Kent	
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 H		Year)	Birthplace (State or Foreign Country)
	207-12-2532 X 80 Yrs.	55,0			Delaware
}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	00			10d. Inside City Limits
5					1 Yes 2 □ No
נו ב	MD Kent Millingto			- 02:(118	**
runeral Directo		10f. Zip Code	10	g. Citizen of WI	nat Country?
ם נו	1606 Dudley's Corner Rd 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21651	/Specify Vac or No.	USA	- American Indian,
5		Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu	lerto Rican, etc.)		, White, etc.
2	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Yes 2 No Specify:		Specify:	1
nbieren	15. Decedent's Education 16a. Decedent	's Usual Occupation	1	Rlac 6b. Kind of Bus	
nd.	(Specify only highest grade completed) (Give kind life. DO life. DO	d of work done during most of v NOT use retired)	working		,
5		e Tender	c	onstru	action
מ	17. Father's Name (First, Middle, Last)		Name (First, Middle, M	aiden Sumame)
2	Edward Thomas	Alice	Pinkney		
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or		City or Town, S	itate, Zip Code)
	Gladys Thomas -wife 1605 D	udley's Corr	nor Rd Mi	11ingt	on. MD
	20a. Method of Disposition 20b. Place of Disposition	n (Name of			City or Town, State
	X XBuriai 2 Cremation 3 Hemoval from State	sant Cem 2/2	26/05 P	ondtow	m MD
Ì		ame and Address of Facility	20/03 F	Ondtow	VII, PID
	Ben Ben	nie Smith FF	H-Worton	MID	
	23a. Pirt1 Enter the disease, or complications that caused the death. Do not enter the		The second secon		Approximate
j	show, or heart failure. List only one cause on each line.	12-			Interval Between Onset and Death
	disease or condition resulting in death) Due to (or as a consequence of):	aown			10 day
	dialet Nobl	pathy + the	the Aten		NA ST
0		poury - 11	Herman		1000
	cause. Enter Underlying Cause (Disease or injury that initiated events	•			
LAG	resulting in death) Last Due to (or as a consequence of):				
alca!	d				
				.,	
171	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ect	opic pregnancy		23d. Date	of delivery
olcial II	1 Ves 2 No 4 Pregnant at time of death 5 Ot	her (specify)		Mont	h Day Year
2	9 ☐ Unknown				
D Y	Part II. Other significant conditions contributing to death but not resulting in the under	tying cause given in Part I.	23e. Did toba	cco use contrib	oute to the cause of death?
מ	(1 COP) With The ration &	forestory from	1 Yes	2 □ No 3	Probably 4 Unknown
חומות	(2) Adimanie Hans	, , , , , , , , , , , , , , , , , , , ,	24a. Was an	24b. We	ere autopsy findings available
5	3 (a ha) de la cataral Di	ekex	autopsy perform	ed? de	or to completion of cause of ath? Yes 2 No
ָ ט	25. Was case referred to medical		1 ☐ Yes 2! Death (Check only one)		
2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other	g Home 5 - Residen		(Specify)
	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how		
	1 ☑ Aatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
2	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street.	factory, office	28f. Location (Stre	et and Number	or Rural Route Number.
Medical Cel IIIIcalion	4 ☐ Homicide building, etc. (Specify)		City or Town,	Siare)	
10	29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death oc	curred at the time, date and pla	ace, and due to the cau	ise(s) and manr	ner as stated.
2	(Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death or	ccurred at the time, dat	e and place, an	d due to the cause(s)
TA I	29b. Signature and title of certifier	29c. License number	290	d. Date signed ((Month, Day, Year)
	1611. Wein mp	721313		2/21/0	05-
+	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin			- / - 1/0	_
	KIN K. WUN, 415 Washington		entown, N	11) 70	1620
	31. Date filed (Month, Cary Year) 4 2005 32. Paistrar's Signature	, , , , , , , , , , , ,	- corn	, , ,	
	LED 0 4 COOL	all ,			

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	For	State of Maryland / Department of Health and Menta	ıl Hygien♥
_	State Registrar	Certificate of Death	Reg. No.

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1	rail.	State of Maryland / Department of Health	n and
	1 - For State Registrar	Certificate of Deat	h
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)	-	1 - State Registrar		Cer	tificate of D	eath	1	Reg. No.	000	01006.
			1. Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Hattie Elizab	eth Thomas				Feb.	20	2005	1:30 PM M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or L	ocation of Death		4c. (County of Death	
			Caroline Nursi	ng Home		Dent				Carolin	
	Funeral Director		075-18-6009	M 2 A F 87	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bin (Month, Da Nov. 6,	1917	9. Birth Cou Mary	place (State or Foreign intry) y Land
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				T	10d. Inside City Limits
	Aaryl sho	ō			Dantan						1 ☐ Yes 2 ₹ No
	28a-	ect	Maryland Carol 10e. Street and Number	ine	Denton	10f. Zip Code			10g. Citiz	zen of What Cou	intry?
	with sa or	Funeral Director	8351 Harmony Road			21655			USA	A	
	Has 2:	era		2. Was Decedent Ever	in U.S. 13. y	Vas Decedent of Hist	panic Origin? (Sp	ecify Yes or No	. 1	4. Race - Amer	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meulcal Evacultar must be notified at once.	by	1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	Armed Forces? 1 Yes 2 MNo If Yes, Give 1 Year or Dates:		f Yes, specify Cuban,	Specify:	Hican, etc.)		Black, White	lack
Ö	2 ho	Completed	15. Decedent's Edu		16a. Deced	lent's Usual Occupati kind of work done du	ion	ina	16b. Kin	nd of Business/li	ndustry
218	e. en "r	ed c	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	ing most or work	n ig			
21	or the	200	9		Но	use Keepe					amilies
nd	be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)			1	18. Mother's Name	e (First, Middle,	Maiden S	Sumame)	
yla	should to marked umatic a	2	Samuel Taylor				Mary Fo	untain	Tayl	or	
Maryland	2 she and is m		19a. Informant's Name/Relationship (Ty			g Address (Street an					ip Code)
	and lealth m 27 her tr		Ethel Jessup, Dau		05. Place of Dispo	lamony Roa		Date		cation - City or T	Town State
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		cemetery, cren	natory or other place))				
Ē	Pag tment tant: jury		`4 □ Donation ´5 ^t □ Other (Specify)			Crematory	1	-2005	Dov	er,Dela	ware
Baltimore,	permit. Departr Importa any inju		21. Signature of Fluneral Service License	rince	H Z	Name and Address Bennie Smi 26 Dover	th Funer Street,	Easton,	Mary	1and 21	601
	47		23a. Part. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the e cause on each line.	death. Do not ent	er the mode of dying,	such as cardiac	or respiratory a	rest.		Approximate Interval Between Onset and Death
MA.	Physician		Immediate Cause (Final disease or condition	Alzhe	EIMPA	a Ser	1ent	10			vears
	/Medical		resulting in death)	Due to (or as a cor	nsequence of):						1
45.	Examiner		Sequentially list conditions,								
	D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (Ur as a cui	الا فعاد فعلوه						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
0,	e exe		resulting in death) cast	Due to (or as a con	nsequence or):						
68760,	the p	Medical									
9	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Med	IF FEMALE:	2. 16							
Вох	ath cuttend	lan	23b. Was decedent pregnant in the past 12 mg/hths?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3 L	Ectopic pregnancy			2	23d. Date of dele Month	very Day Year
0	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	ordeath 5	Other (specify)					
Q .	that the died by the detached	Completed by Physician	Part II. Other significant conditions cor	tributing to death but no	t resulting in the u	nderlying cause giver	n in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
ds,	ires tha signed I d be det	d b						1 🗆	Yes 2[No 3□Pro	bably 4 Unknown
Records,	v require been sig should b	ete						24a. Was	an	24h Were au	tonsy findings available
3e	e lav has je 2	μ						auto		prior to death?	topsy findings available completion of cause of
a						-		1 Yes	2 No	1 Yes	2 No
Vital		Be	25. Was case referred to medical examiner?	lospital:	a∏50/0	Other	26. Place of Deat			G ☐Other (Spec	ni4.)
of		. To	1 ☐ Yes 2 ☑ No 27. Manner of Death		2 ER/Outpatier 28b. Time of			28d. Describe			ary)
Division of	Attending F r death. sctor: After by the funer	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury		? es 2 □ No				
İSİ	Attend death ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, str	reet, factory, office		28f. Location (Street and	d Number or Ru	ral Route Number,
á	after Dire d in b	erti	4 Homicide	building, etc. (S	pecity)			City or To	wn, State)	,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the time vestigation, in my opi	e, date and place, inion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	00		29c. License	number		29d. Date	e signed (Month	n, Day, Year)
	⊢ 3 ⊢ ō) James	Siklo.	~ MT	D3	1376		2-0	12-00	3
			30. Name and address of person who co	impleted cause of death	(Item 23a) (Type.	Print)	010		_		
			James Sille	5 920 1	Market	- St N	entor	, M	06	21629	7
			24 Date filed (Month Day Yors)	22 Parter	Cionaturo						

State Registrar

		1 - State AMENDED 31,2/22/05,LD Registrar 1. Decedent's Name (First, Middle, Last)		ertificate of	Death	2. Date of Death		3. Time of Deat
iysici Medio		Mary Alice Tirrito				February	Day Year 16 2005	- 1225
kamir	ner	4a. Facility Name (If not institution, give street and number MEMORIAL HDSPITA	•		r Location of Death	1	4c. County of Dea	
- anal		7 7 - 0/ 1.71	Age (In yrs. last birthda)		4 570 U If Under 24 Hrs.	8. Date of Birth	TALB	
neral ector		083-20-5340 1 M 2 F Usual Residence of Decedent	90 Yrs.	Months Days	Hours Min.	Jan. 20,	1915 S	other (State or Forecountry)
14		10a. State 10b. County	10c. City, Town or I	Location	<u> </u>			10d. Inside City Lin
tiffed	cto	Maryland Talbot		Easton				1 ∰Yes 2□
bear	Funeral Director	10e. Street and Number		10f. Zip Code	- 4 0	10	g. Citizen of What C	country?
Tales of	erai	7435 Casey Avenue			513		USA	
edical Examiner must be notified at	Fun	11. Marital Status 12. Was Decede Armed Force 1 Never Married 2 Married 1 Yes 2	es?	 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puero	Decify Yes or No- Dican, etc.)	14. Race - Am Black, Wh	
Exa	by	3 ∰Widowed 4 □ Divorced If Yes, Give Year or Date		1☐ Yes 2⊡ No	Specify:		Specify:	White
경	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retired	ation during most of work	kina 16	6b. Kind of Business	s/Industry
N A	Idm	Elementary/Secondary (0-12) College (1-4c	Of 5+)	DO NOT use retired aitress	d)		D 1	
ent, II	e Co	17. Father's Name (First, Middle, Last)	We	artress	18. Mother's Nam	ne (First, Middle, Ma	Restaura	ant
	To B	George Mann				Wilson	,	
		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	iling Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
Ter tr		Barbara A. Dabrowski/Daug		5 Casey Av			21601	
any Injury or other traumatic event, once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from Sta	20b. Place of Disp cemetery, cri	position (Name of rematory or other place	ce)	Date 20	Oc. Location - City of	r Town, State
ulury		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	MidShore	eCremation	nCenter 2	/17/2005	Cambridge	e, MD
any li		Miles Andrews	271.100	22. Name and Addre Curran-Bro 308 High S	es of Facility Smwell Fu	neral Hom	ne, P.A.	
		23a. Rattl. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arres	t.	Approximate
ian		Immediate Cause (Final	ngestive	1	1 /	Luna		Interval Between Onset and Deatl
cal ner		resulting in death)	as a consequence of):	nar 1	1 141	1		LWee
iei	_	Sequentially list conditions, b. D.	ated Co	ardion	1 yupa,	My		xears
	Examiner	cause. Enter Underlying Cause (Disease or injury	as a consequence of):		,	/		
		that initiated events c	as a consequence of):					
	Icai							
	Physician/Med	IF FEMALE:						
	ian/	III the past 12 months?	2 Fetal death 3	□Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
	ysic	1 ☐ Yes 2 🔼 No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown		Other (specify)				
	by PI	Part II. Other significant conditions contributing to death	h but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death
		prevmonia				1 ☐ Yes	2 □ No 3 □ P	robably 4 Junkn
	Completed					24a. Was an autopsy		utopsy findings avai completion of cause
	Con					performe	d? death?	
	Be	25. Was case referred to medical examiner?		0.1		th (Check only one)		
	J.	1 Yes 2 No Hospital: 1 Inpa			4 Linuising no	ome 5 Residen	ce 6 ☐Other (Spe	ecity)
		1 Satural 5 Pending (Month, I	Day Year) Injury	Worl	k? Yes 2 □ No	200. Describe now	injury occurred	
	tlon		Injury - At home, farm, s	treet, factory, office		28f. Location (Stre	et and Number or R	ural Route Number,
	ification	determined 286. Place of				City or Town,	Siale)	
	Certification:	determined 286. Place of	etc. (Specify)					
Ď		4 Homicide determined 288. Place of building, 29a. Certifier (Check only 2 Medical Examiner: On the besis	est of my knowledge, dea s of examination and/or in	ath occurred at the tim	ne, date and place, pinion, death occur	and due to the cau	se(s) and manner a: e and place, and due	s stated. e to the cause(s)
9	Medical Certification	4 Homicide determined 28e. Place of building. 29a. Certifier (Check only one) 29 Medical Examiner: On the besi and nepher	est of my knowledge, dea s of examination and/or in stated.	investigation, in my of	pinion, death occur	red at the time, date	and place, and due	e to the cause(s)
iner.	edical	4 Homicide determined 28e. Place of building. 29a. Certifier (Check only one) 29 Medical Examiner: On the besi and nepher	est of my knowledge, dea s of examination and/or in stated.	investigation, in my of	pinion, death occur	red at the time, date	and place, and due	e to the cause(s)
completely filled in by the funeral director, page 2	edical	4 Homicide determined 28e. Place of building. 29a. Certifier (Check only one) 29 Medical Examiner: On the besi and nepher	ist of my knowledge, dea s of examination and/or is stated.	investigation, in my of	pinion, death occur	red at the time, date	and place, and due	to the cause(s)

			1 - For State Registrar	State of M	1 arylar				lealth and <i>Death</i>	Mental Hy	gien Reg. Ñ	000	07834
	Discostati	3	1. Decedent's Name (First, Middle, La	ist)		•			-	2. Date of De	aath Da	ay Year	3. Time of Death
	Physici /Medic		Kathryn To	dd Tolley	<i>Y</i>					Februa		0 2005	4:03 a. M
	Examir		4a. Facility Name (If not institution, gir		r)		4b. City		r Location of Dea	ath	40	c. County of Death	
			William Hill		//	14 bint d	If I lade	Eas	ton			Talbot	
	Funeral Director		,	Sex 7.A 1□M 21 5 4F	.ge (<i>in yr</i> s. 82	last birthday) Yrs.	Months		Hours Mir	1. (Month, D	ay, Year	9. Birth	place (State or Foreigr intry)
			Usual Residence of Decedent		- 02					August	13,	1922 M	aryland
	ylanc how		10a. State 10b. County		10c. Ci	ty, Town or Lo							10d. Inside City Limits
\mathcal{C}	B-f s	cto	MD Dorche	ster				Wool	ford				1 ☐ Yes 2 📉 No
Š	ith the	Director	10e. Street and Number				10f. Zi	p Code			10g. Ci	itizen of What Cou	intry?
8	ath w		4906 Mallard Co						21677			USA	
8	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Mudical Examiner must be multihed at	Funeral	11. Marital Status	12. Was Deceden	3	.S. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or No irto Rican, etc.))-	 Race - Ameri Black, White 	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 ☐ If Yes, Give Year or Dates			1 🗆 Yes	2 X No	Specify:			Specify: Wh	ite
Ö	2 hou		15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occup	ation		16b K	Kind of Business/Ir	dustry
215	hin 72	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-40)	· 5.4.\	(Give	kind of wi DO NOT L	ork done d ise retired	during most of w f)	orking			
5	giene giene er tha	mo;	11	College (1-40)	3+)		ham	emak	er		(own Home	
b	be filed Ital Hygid of other	Be (17. Father's Name (First, Middle, Last	•						ame (First, Middle		n Sumame)	
<u>S</u>	should tand Ment s marked	၉	Bradye Rumford	Todd					Mary	Ann Will	_ey		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Widdel Examiner mat be mailted at		19a. Informant's Name/Relationship	Type, Print)		1						or Town, State, Zij	o Code)
	1 and Health em 27 ther tr		Andrew Tolley		son				Cove, Wo	olford,		21677	
0	Pages 1 nent of h int: If ite iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	• 0	Place of Dispo cemetery, crer	natory or	other plac	1	Date		ocation - City or T	
Baltimore,	I. Pa ntmen ntant: njury		`4 □Donation 5 □ Other (Speci		Doi	cheste	er Me	moria	al Park	2/22/05	Car	mbridge,	MD
Ba	permil. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra 20009.		21. Signature of Funeral Service Lice	nsee								al Home I	P.A.
			23a. Part 1. Enter the disease, or con	polications that cause	d the deat					ambridge		21613	Approximate
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence of a consequence of the consequence	uence of):	air 100	n Su phi	yndri alite	me			Interval Between Onset and Death Onset and Death Oyrs Oyrs
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial transit	by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or a	of pregna 2 ☐ Feta	ancy	Ectopic p	regnancy				23d. Date of deliver	ery Day Year
0	the d	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of d	eath 5∟	Other (s)	oecify)					
۵.	res lhat t signed by be detac	/ Ph	Part II. Dther significent conditions	contributing to death	but not res	ulting in the ur	ndertying o	ause give	en in Part I.	23e. Did t	obacco i	use contribute to t	he cause of death?
SD	uires 1 sign 1d be	d b								10	Yes 2	≥Ro 3 Prot	pably 4 □Unknown
Records,	w requir been si should	Completed								24a. Was	an	24h Were auto	psy findings available
Re	he tav e has age 2	mc								autor	rmed?	prior to co death?	mpletion of cause of
Vital		0	25. Was case referred to medical						26 Place of De	1 ☐ Yes eath (Check only o	2	1 □ Yes	2LINo
	Physician: this certificatal director, i	To B	examiner? 1 Yes 2	Hospital:	ient 2 🗆	ER/Outpatien	t 3 🗆 D(OA Othe				6 □Other (Specif	·v)
0	문 두 등		27. Manner of Death	28a. Date of Inj (Month, D.	ury	28b. Time of		28c. Injury Work		28d. Describe			<i>y/</i>
Ö	utending I death. ctor: After y the funer	atlo	1 ∠Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	ay roar,	mjury	М		res 2 □ No				
Division of	000	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	jury - At ho tc. <i>(Specif</i>	ome, farm, stre	eet, factor	y, office		28f. Location (S City or Tox		nd Number or Rure e)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Example 1	nysician: To the best miner: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurred restigation	at the tim	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) date and) and manner as s d place, and due to	tated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Mn		^		c. License		_		te signed (Month,	
			30. Name and address of person who AVOVSA BO 31. Date filed (Month, Day, Year)	Ull	me			DE	35284	<i>+</i>	21	20105	
			30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)	100	hinal	in CL	500	of no	13/1.
			31 Date filed (Africa) Day Vocal	ear m	(1)	47.	J. C	uc 1	our yr	un of c	_~ 1	in on my	460/
	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 2 2		rar's Signa		head	80	-				

			1_ For State	State of N		d / Depa	artmen	t of H	ealth a	and M	lental Hyg		n s	07025
			1 - State Registrar			Ce	rtificat	e of L	Death			eg. Nö.	UU	07033
	Physici	an	Decedent's Name (First, Middle, La	st)							Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Arthur Robert To	dd							February		2005	13:03 M
	Examin	er	4a. Facility Name (If not institution, giv	e street and numbe	1) 1	a. bel	4b. City,	Town, or	Location of	of Death	,	4c. Cou	No Death	
			YENINGUIA KEGIONA	Mealer	Co	MU	If Under	541156	If Under	24 Hrs	0. Date of Birth		<u> </u>	
	Funeral Director		5. Social Security Number 6. S 218-34-9221	ex 7. A M 2□F	73	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Nov • 15	Year) 1931	Mary	place (State or Foreign ntry) Land
	D		Usuat Residence of Decedent											
	anylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 X No
\mathcal{O}	8a-f	Director	Maryland Wicomico			Salis								
3	with th		10e. Street and Number				101. Zip	Code				-	of What Cou	ntry?
)	s 23	rai	7456 Titleist Dri	.Ve 12. Was Deceder	t Ever in II	C 12	Was Dass		21801	iain? (Sn	noifu Vac or Na		USA Race - Ameri	can Indian
): :	Item de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Amed Forces	?	.3.	If Yes, spe	cify Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
99	hours after death with the Maryland tursi', or ttems 23a or 28a-f show al Examiner must be notified at	þ	3X Widowed 4 □ Divorced	tf Yes, Give Year or Dates			1 🗌 Yes	2 X No	Specify:			Spe	city: Wi	nite
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or litems 23a or 28a-1 show event, the Medical Examiner much be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usu	al Occupa	ation	t of work	ina	16b. Kind o	f Business/Ir	dustry
215	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT u	se retired)		9			
2	filed wi Hygien other th	So	11			Maint	enan	ce Si			(5:	Poult		
<u>n</u>		Be	17. Father's Name (First, Middle, Last					1			e (First, Middle,	Malden Sun	iame)	
3	should I nd Meni marke umatic	2	Wesley Towers Tod			10h Maili	na Addrasi	(Steamt)			ister A <i>l Ro</i> ute Numbe	City of To	ın State 7i	Codo)
Ma	d 2 sk th and 7 ls r	11 3	Cindy Wright/Daug	,, ,			-				Easton	-		
	s 1 and 2 should f Health and Mer item 27 is merke other traumatic	1	20a. Method of Disposition	11001	20b. F	Place of Disponentery, cre	-				Date		on - City or T	
5	0 = 5		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation — □ Other (Special		.6	emetery, cre zy Wash			1	/25/	2005	Hurloc	k Ma	ryland
Baltimore,			21. Signature of Fun ral Service Lice		11	2								
Ba	permit. Departn imports any inju		Memme	list Se	lle	1 Ze	ller 06 Ma:	Fune in St	eral :reet	Home • Ea:	, P. O. st New N	Box 2 Market	07 MD 2	21631
			23a. Perty. Enter the disease, or com shock, or heart failure. List only	pications that caus	ed the deat	_								Approximate Interval Between
	Pnysician		tmmediate Cause (Final	one cause on each	illie.	0 1	11 -	0						Onset and Death
	/Medical		disease or condition resulting in death)	a: Due to () r a	as a conseq	uence (f):	Let	e.	~					764.
	Examiner		Sequentially list conditions	b. Al	al	ch								They
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		as a conseq	uence of):					6) . "
	and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or s	as a conseq	uence of):	-65	19	20	1	100		^	~ Cho
760,	te be executed ysician and e burial-transit	cai E		Due 10 (01 2	12 Collised	7		1						77.
687	9 × 9		•	d	111									192,
× 6	The law requires that the death certificat tite has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	ne of pregna	ancy						23d.	Date of deliv	erv
Вох	eath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant			□Ectopic p □ Other (s _i					3.0	Month	Day Year
0	that the de led by the detached	hysi	9 Unknown	9□ Unknown										
۳,	es that igned to be det	by P	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	underlying (cause giv	en in Part I	t.				he cause of death?
rg	w require been sig should b					<u>.</u>					1 🗆 Y	es 2□No	3 Pro	bably 4 Unknown
Records,	law re as be 2 sho	Completed									24a. Was a autops		b. Were auto	opsy findings available ompletion of cause of
Ä		, mo									perfor	med? 2 □ No	death?	
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medicat examiner?					72.		e of Deat	h (Check only or	ne)		
of \	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ NO	Hospital: 1 Impa		ER/Outpatie			4 🗆 140		me 5 Resid			(y)
	ft and and and and and and and and and and	lon	27. Manner of Death 1 Natural 5 Pending		Day Year)	28b. Time o Injury	M	28c. Injun Worl	yat k? Yes 2 🗍		28d. Describe h	ow injury oc	currea	
isi	Attending or death. ector: Atterby the fune	icat	2 Accident investigation 3 Suicide 6 Could not to	00 - Dta	Injury - At h	ome farm st			163 2	110	28f, Location (S	treet and Nu	ımber or Rur	al Route Number.
Division	after Direction by	Certification;	4 ☐ Homicide determined	building,	etc. (Specil	(y)	1001, 140101	y, onico			City or Tow			
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying P	hysician: To the be	st of my kno	wledge, dea	th occurred	at the tin	ne, date ar	nd place,	and due to the c	ause(s) and	manner as s	stated.
	n 24 h n 24 h he Fu	Medicai	(Check only 2 Medical Exa	miner: On the basis and manner	of examina stated.	ation and/or in	nvestigation	n, in my o	pinion, dea	ath occur	red at the time, c	late and plac	ce, and due t	o the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of sertifier	^	- 44		29	c. Licens	e number			29d. Date siç	ned (Month,	Day, Year)
				enul	A	0		110	000	-1.	327	4	1/05	
			30. Name and address of person wh	completed cause of	death (tter	n 23a) (Type	Print)	11.	11	1/11	VIM A	20		
				M.D. /	strar's Signa	ature	•		2/1	1100	ury "			
	Sta Regist	ate rar	31. Date filed (Month Day, Year)	JU05	ر معن	K A	souli	•			and due to the cred at the time, of			
				HEAT.										

				partment of Health and Men	tal Hygiene Reg. No.	005 07836
	Physic /Medi		Decedent's Name (First, Middle, Last) MELBA GRACE TOOLEY		Date of Death Month Day	Year 3. Time of Death 8, 12 M
	Exami		4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL	4b. City, Town, or Location of Death Hagerstown	4c. (County of Death
	Funeral Director		5. Social Security Number 543-34-7996 G. Sex 1 M 2 M F 7. Age (In yrs. last birthda 70 Yrs.	Months Days Hours Min. (Pate of Birth Month, Day, Year) AY 21, 193	9. Birthplace (State or Foreign Country) OREGON
	e-f show	ctor	10a. State 10b. County 10c. City, Town or MARYLAND WASHINGTON	Location ROHRERSVILLE		10d. Inside City Limits 1 ☐ Yes 2☐ No
	ath with the 23e or 28	ral Dire	10e. Street and Number 4401 MAIN STREET	10f. Zip Code 21779		en of What Country? U.S.A.
9000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Exament must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ Yes 15. Was Decedent Ever in U.S. If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica Yes 2\overline{\text{M}}\text{No Specify:} 		4. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	ad within 72 trigione. er than "nate", the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) L	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired) TEACHER		d of Business/Industry RIVATE ELEM. SCHOO
Maryland	2 should be filed within and Mental Hygiene. I la marked other than "reumatic event, I'm Men	To Be	JOHN M. DOWNS	18. Mother's Name (Fir	LENORA HA	AYNES
Baltimore, Mar	perriit. Pages 1 and 2 st Department of Health and Important: If Item 27 I an any injury or other treur once		PAUL E. TOOLEY, SR., SPOUSE 20a. Method of Disposition 1X Burial 2 Communication 3 Bernoval from State cemetery, or	Alling Address (Street and Number or Rural Ro. O1 MAIN STREET, ROHRED Reposition (Name of rematory or other place) T VIEW CEM. 2/23/200	RSVILLE 1	
Baltin	pernit. F Departmo Importar any njur			22. Name and Address of Facility	7606 OLD 1	NATIONAL PIKE , MARYLAND 21713
	Physician /Medical		23a. Part 1. Enter the Mease, or complications that caused the death. Do not e shock, or heart fall the trial only one cause in each line. Immediate Cause (Final disease or condition resulting in death)	enter the mode of dying, such as cardiac or res	piratory arrest,	Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Stock. Alveoler Henorshay	٠ '	2 Months
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi		B⊟Ectopic pregnancy 5 ☐ Other (specify)	23	dd. Date of delivery Month Day Year
rds, P.	quires that an signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death? No 3 ☐ Probably 4 ☑ Uniknown
Il Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ion of Vital	Attending Physician: Thradeath. octor: After this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at 28d. I		
Division	Hospital or Atten 24 hours after death Funeral Director: (tely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, State)	Number or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1	ath occurred at the time, date and place, and d investigation, in my opinion, death occurred at 29c. License number	the time, date and p	lace, and due to the cause(s)
	F 18 5 8		30. Name and address of person who completed cause of death (Item 23a) (Type	D 47288		signed (Month, Day, Year) 22, 2005
5H	1-10 Sta	10	Dr. Sabel 12821 Oak Au 31. Date filed (Month, Day/Year) 32. Benistrar's Signature	il Are 1-tog. 11	d. 2174	2
*	Registr		FEB 2 4 2005	resks		

			Please	State of Mar				•	•	
			1 - For 2-23-05		0	ertificate of			eg. No.	5 0/83/
A. S.	, n		Registrar Amend #20b. 20 1. Decedent's Name (First, Middle, Las	t)	er	Timodic or		2. Date of Deat	th	3. Time of Death
	Physicia /Medic		Doris	Emma	Tyler			Feloruar	y 17 20	
	Examin	er	4a. Facility Name (If not institution, give Doctors Hospita			4b. City, Town, o	r Location of Death ham		4c. County of D	Georges
	Funeral		5. Social Security Number 6. S	7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, 12-29-	Yearl 9.	Birthplace (State or Foreign Country) Sh. DC
	Director		5 7 8 / 3 2 / 3 3 6 6 Usual Residence of Decedent	→ M 2 X F	79 Yrs.			12-29-	1925 Wa	sh."DC
	arylan show	_	10a. State 10b. County		Oc. City, Town or l					10d. Inside City Limits 1-√2 Yes 2 ☐ No
	the Ma	Director	MD Prince	Georges	Upper	Marlbor	0	1	0g. Citizen of What	**
	n 72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show krifted Exerci at Fransi La Frolithe Jat	ai Dir	1 Cameron Grov	e Blvd. #	103		774		USA	Country :
	ems ?	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian, /hite, etc.
20	72 hours after neturel', or Ite	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:	,	Specify:	Black
2-003	r2 hou		15. Decedent's Ed (Specify only highest gra	lucation	16a. Dec	edent's Usual Occup e kind of work done	pation	ring .	16b. Kind of Busine	ess/Industry
Ž	within 7 ene. then "r	ompleted	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d) -		TT G . 4	
7	iled w lygier her th	O	1 Z 17. Father's Name (First, Middle, Last)		Libr	arian T	ecnnicia 18. Mother's Nam		US Army	
	ld be fi ental H ked ot ic ever	o Be	Clodie Freema				Sallie	Pott		
lary	s 1 and 2 should by f Health and Menta item 27 is marked other treumatic e	F	19a. Informant's Name/Relationship (Richard Tyler/		19b. Mai	ling Address (Street	and Number or Run	ral Route Number	City or Town, Stat	e, <i>Zip Code)</i> r Marlboro,
e 0	1 and Health em 27 ther t		20a. Method of Disposition		20b. Place of Disc	osition (Name of	1	-	20c. Location - City	
Ē	m O b.		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	Maryland Harmony	Veteran splan	en 28 ark 2 - 2 1		heltenham, Landove	
бащто	permit. Page Department Importent: If eny injury or		21 Signature of Funeral Service Licen			22. Name and Addre	ess of Facility Tav	lor's	Funeral	Home
D	90 E 9 9		Monald	Jank the	1	122 Nort	th Capit	ol St.	NW Wasi	1. DC 20002
			23a. Part Enter the disease, or com shock, or heart failure. List only	ication that caused the one cause on each line.	ne death. Do not ei	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Dun to for as a	consequence of):					DAY,S,
	Examiner		Conventinity first and distance	PNEC	MONIA					DAYCS)
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					2
_6	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	CT INFEC	Clary			DAYCS)
00/	ysiciar ysiciar	cal		d						
9	ortifica ing ph a as th	Medi	IF FEMALE:							
X D	that the death certificate ed by the attending phys detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death 3	☐Ectopic pregnancy	y		23d. Date of Month	delivery Day Year
	the de by the ached	hysic	1 Yes 2 No 9 Unknown	9☐ Unknown	no or dodding 5					
λ, T	The law requires that the death certificate ite has been signed by the attending phys age 2 should be detached for use as the	by P	Part II. Other significant conditions of	-	-	underlying cause giv	en in Part I.			e to the cause of death?
00	v requir been si should		RIGHT FOOT	GANGKEN	(-					Probably 4 ØUnknown
vitai Records,	has b	Completed						24a. Was a autops perforn	y prior	autopsy findings available to completion of cause of 1?
		e Co	25. Was case referred to medical	_			26 Place of Deat	1 ☐ Yes 2		es 2⊠No
<u> </u>	ysicien: ils certific director,	Po B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth			ence 6 Other (5	pecify)
on or	ding Ph h. After th funeral	tion; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	(ear) 28b. Time Injury	Wor	y at rk? Yes 2 □ No	28d. Describe ho	ow injury occurred	
DIVISION	e Hospitel or Atten 24 hours after deati e Funerel Director: letely filled in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, s (Specify)			28f. Location (St. City or Town		Rural Route Number,
2	spitel cours af		29a, Certifier 1. Certifying Ph	ysician: To the best of	my knowledge des	th occurred at the tir	me, date and place	and due to the ca	ause(s) and manner	as stated
	n 24 ho	edicai		niner: On the basis of each manner state	xamination and/or i					
	To the within To the comple	M	29b. Signature and otle of certifier			29c. Licens			9d. Date signed (M	
_^			I arand Hac			1100	058275		2-17-	D
PL	(3)		30. Name and address of person who PARAND ALAVI, M			d. LANHA	M, MD 20	706		
	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar			,			
	Registi	ar	FEB 2 3 2005	Die	A 147					

			For Stata Registrar	State of Mar	yland	-	rtment c			nd Mer		ene g. v. 005	07838
	Physicia		DORIS ANNA WI	st) EINBERG							Date of Death Month ebruar		3. Time of Death 5 4:55 A M
	/Medic Examin		4a. Facility Name (If not institution, given		Apt	#512	4b. City, Tov		cation of 0	Death		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (st birthday) Yrs.	If Under 1 Y Months D		Under 24 lours	Hrs. 8.	Date of Birth (Month, Day, pril 2	9. Bi 2,1923 C	rthplace (State or Foreign country) onnecticut
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon		•	Town or Lo	Spring						10d. Inside City Limits 1X Yes 2 ☐ No
	or 28a	Direc	10e. Street and Number				10f. Zip Co	de			10	g. Citizen of What C	country?
	eath w	erall	3701 Internation	nal Drive, A			209		nic Origin	n? (Specify	Yes or No-	U.S.A.	erican Indian
920	72 hours after death with the Maryland natural; or itams 23a or 28a-f show Jisal Evantraermust te notified at	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	61 11 0.3.	1	Vas Decedent Yes, specify ☐ Yes 2점		Mexican, F	Puerto Rica	an, etc.)	Black, Wh	ite, etc.
21215-0036	vithin 72 ho na. han "natur n Medical	mpleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)		(Give life. [lent's Usual O kind of work d OO NOT use re	one durit etired)	n ng most o	of working	1	6b. Kind of Business	
land 2	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: if item 27 is marked othar than "naturat; or items 23a or 28a-1 ahow any fully or other traumatic event. If a Medical Examination must be notified at once.	o Be Co	17. Father's Name (First, Middle, Last Albert Guhring			п	omemak	18.	. Mother's Mart		irst, Middle, M	Own Ho	me
Maryland	nd 2 shou lith and M 27 is mari		19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •								City or Town, State,	
Baltimore,	bages 1 avent of Heam vor other		20a. Method of Disposition 1 Burial 2 Cremation 3 Other (Speci		cen	netery, cren	sition (Name of natory or other	r place)	ory	Date 2/25/		oc. Location - City o	rTown, State Maryland
Balti	parmit. I Dapartm Importal any inju		21. Signature of Funeral Service Lice	4 -	2				1 -			A	ng, MD 20904
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or conshock, or bear failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unious or injury.	plications that caused the one cause on each line. a	*/ */ \$ &	Do not ente							Approximate Interval Between Onset and Death 2 0 YEAR 5
68760,	tificate ba axecuted ig physician and as the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or as a d	conseque	ince of):							
P.O. Box	death cer e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal d	leath 3□	Ectopic pregr Other <i>(specil</i>					23d. Date of de Month	elivery Day Year
	Se US	by	Part II. Other significant conditions CER PULMON		not result	ing in the ur	nderlying caus	e given ir	n Part I.				to the cause of death? Probably 4 □Unknown
Vital Records,	0 - 0	Completed	PAZNEUL OST	EO POROS Z S						_	24a. Was an autopsy perform	ed2 prior to death?	autopsy findings available completion of cause of
ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?								heck only one)	
of	ding Phys n, After this funeral di	ို	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	2	R/Outpatien 28b. Time of Injury		Injury at Work?		28d		nce 6 □Other (Sp w injury occurred	ecify)
Division	el or Attendes s after deatl il Diractor: od in by the	Certification;	3 Suicide 6 Could not to determine determined			ne, farm, str	eet, factory, of	fice		28f.	Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospitel or Atte within 24 hours after de To tha Funaral Diracto completely filled in by th	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of minar: On the basis of e and manner state	xaminatio	ledge, death on and/or inv	occurred at to restigation, in	he time, o my opinio	date and on, death	place, and occurred a	due to the car at the time, da	use(s) and manner a te and place, and du	as stated. le to the cause(s)
)		Me	29b. Signature and title of certifier	sale uo				cense nu			t t	d. Date signed (Mor EBRUARY 2	
	10		30. Name and address of person who		th (Item 2	23a) (Type,	Print)	10 5	UZI	e 21.	3, 6 1.	theisbury.	MD 20877
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 2 2	32 Registrar	s Signatu	ire Sol	We .						

		1 - State Registrar		partment of Health and ertificate of Death		ene 2005	07839			
Physicia /Medic			Walker		2. Date of Death Month February		3. Time of Death 9:50a M			
Examin	er	4a. Facility Name (If not institution, give street and numb Prince George's Hospita 5. Social Security Number 6. Sex 7.		4b. City, Town, or Location of Dea Cheverly (i) If Under 1 Year If Under 24 Hr.		4c. County of Death Prince Ge	_			
Funeral Director		579-12-9928 Usual Residence of Decedent	85 Yrs.	Months Days Hours Min		1919 West	lace (State or Foreign try) Virginia			
ne Marylan 8a-f show	ctor	Maryland Prince George	Temple H			1	0d. Inside City Limits 12 Yes 2 No			
ath with the 23a or 2	rai Dire	3420 Rickey Avenue		10f. Zip Code 20748	100	G. Citizen of What Coun United Sta	•			
ine, intellylating Z.I.Z.I.S-D030 s.1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if Health and Mental Hygiene. other Z.I.s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ₩No	. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: B1				
within 72 ho ene. than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	or 5+) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking	Sb. Kind of Business/Ind	·			
Lalyidild K. I.K. Should be filed within and Menta! Hygiene. is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be Co	17. Father's Name (First, Middle, Last) George Walker	Cler		me (First, Middle, Ma	ederal Gove	Timent			
~ ~ ~ ~ ~ ~		19a. Informant's Name/Relationship (Type, Print) Annetta Belton/Daughter	2003	ling Address (Street and Number or R Glendora Drive,	District H					
Page nent cant: If ant: If		20a. Method of Disposition 1 Description 3 Removal from St. 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Washingt	on National 2/2	.4/05 St	ic. Location - City or To	ryland			
permit. Departr Imports any inji		Larry L. Simmon	- 5	Name and andrass of Excitor	RU Pike.	Forestvill				
Physician /Medical Examiner		23a. Part1. Enter Me disease, or complications that cau shock, or he if failure. List only one cause on eac Immediate Cause (Final disease or condition resulting in death)	as a consequence of):	Ner the mode of dying, such as cardia			Approximate Interval Between Onset and Death			
	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):							
	n/Medicai	d IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco				23d. Date of deliver	ry			
that the deat ed by the atte	hysician/Me		t at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year			
w requires that been signed should be det	ed by P	Part II. Other significant conditions contributing to deal DIAIDETES	h but not resulting in the	underlying cause given in Part I.		cco use contribute to the				
The law resate has be page 2 shr	Completed	RENAL FAILURE			24a. Was an autopsy performe	d? prior to con death?	psy findings available appletion of cause of			
Physician: The rhis certificate har al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inp	4.4.	ent 3 DOA Other: 4 Nursing I	ath (Check only one)	e 6 □Other (Specify,)			
ng ng	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								
To the Hospital or Attending within 24 hours after death of the Funeral Director. After completely filled in by the fune			Injury - At home, farm, s etc. (Specify)		City or Town, S	, 				
To the Hospital within 24 hours a To the Funeral completely filled	Medical	one) 2 Medical Examiner: On the basi	s of examination and/or i	th occurred at the time, date and place nvestigation, in my opinion, death occu	urred at the time, date	and place, and due to	the cause(s)			
To With	-	29b. Signature and title of certifier Dungled July	ar	29c. License number		2bruery 1				
(1)		30. Name and address of person who completed cases of WENDELL C. FIERSON 31. Date filed (Month, Day, Year)	of death (Item 23a) (Type 300 / strar's Signature	HOSPITAL DR	CHE	abruary 1 EVERLY, 1	MD 20785			
Stat	(e	CCD 9 2 2005	S. a. o orginatoro							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 07840 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death February 20, **Physician** JOHN HARLEY ZEIGLER 2005 6:00A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3204 Dunnington Road Beltsville Prince George's 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1**□**M 2□F 207-05-4571 Director Pennsýlvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic evant. The Medical Examinar must be notified at Prince George's Maryland Beltsville 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3204 Dunnington Road 20705 United States Itams 23a death Funera 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 TXYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify White 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working al Hygiene. Elementary/Secondary (0,12) College (1-4or 5+) Department of Defense N.S.A. 17. Father's Name *(First, Middle, Last)* Robert Monroe Zeigler Mother's Name (First, Middle, Maiden Sumame) Be ss 1 and 2 should be fi of Health and Mental F litem 27 is marked ot Flora Cora Deardorf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra Lee Zeigler -wife 3204 Dunnington Road Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1

Burial 2 □ Cremation 3 □ Removal from State Md. National Mem. Park 2/23/2005 Laurel, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pine / I Service Liver ee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Anti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ophean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatocellular Carcinoma disease or condition resulting in death) 11 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fulsease or injury that initiated events Due to (or as a consequence of): Examine nding physician and use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant led by the attend detached for us 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attanding 24 hours after death. Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D29675 February 21, 2005 12 completed cause of the th (Item 23a) (Type, Print)
6420 Rockledge Drive, #4100 Rockville, Maryland 20817 30 Name and aboress of person who Ralph Boccia, MD 31. Date filed (Month, Day, Year) FEB 2 2 2005 32. Segistrar's Signature MARINE Registrar

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			GOOD SAMARITAN H 5. Social Security Number 6. Sec	OSPITAL 7. Age (In yrs. la	et hirthday)	BALTIM:		rs. 8. Date of I	Dieth.	O Bist	alana (Chaha as Foreign
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≥ ₽ £ 2	: E	1	19a. Informant's Name/Relationship (Ty.	pe, Print) DFRSON	19b. Mailii		et and Number or COONNE	Pural Route Nun	A '	own, State, Zi	
	r other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	1	ace of Dispo	sition (Name of natory or other p		Date	-	tion - City or T	
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Div Hospital or 24 hours afte Funeral Dire	illed in	Cer									
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To the within 2	comp	M	29b. Signature and title of certifier	MD			nse number			igned (Month,	
11/	(1		Vajar/ vaja		20.1	RES-	000		MARCH	1 3th	2005
U	23		30. Name and address of person who co			•	LTIMORE	MD	21239		
Re	Sta egistra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre	e loca			L. C. Life		

ORIGINAL

		•	1 - For State of Maryland / Department of Heal Certificate of Dea		tal Hygien	2005	07842		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) HELEN (GRDELIA AUXIE		ate of Death fonth D ARCH	ay Year Zoos	3. Time of Death		
	Examin		4a. Fecility Name (If not institution, give street and number) NORTHWEST HOSPITAL RAWPALL	STOWN	1	c. County of Death	ORE		
	Funeral Director			ours Min. (A	ate of Birth Month, Day, Yea Ig 8 191	9. Birtl 9 D.C	nplace (State or Foreign untry)		
	Maryland a-f show ified al	tor	10a. State 10b. County 10c. City, Town or Location Sykesville				10d. Inside City Limits 1X☐ Yes 2 ☐ No		
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 10f. Zip Code 21784			itizen of What Co SA	untry?		
920	urs after des el', or Items Examerente	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☐ Year or Dates: 13. Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 ☑ No I ☐ Yes 2 ☑ No Specific Orders 1 ☐ Yes 2 ☑ No	ic Origin? (Specify \angle origin) axican, Puerto Rican ecify:	res or No- o, etc.)	14. Race - Ame Black, White Specify: wh	e, etc.		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, Its Maclical Examiner must be rediffed at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +6 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) business owner a			Kind of Business/l	·		
land 2	12 should be filed within h and Mental Hygiene. 7 is marked other than "Iraumatic event, the Men	To Be Co	17. Father's Name (First, Middle, Last) 18. N	Mother's Name <i>(Firs</i> arlotte B	t, Middle, Maide				
	ss 1 and 2 sho of Health and N item 27 is ma r other trauma	1	19a. Informant's Name/Relationship (Type, Print) Louis William Auxier (son) 19b. Mailing Address (Street and Ni 18612 Meadowland						
Baltimore,			20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation						
Balt	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Service Licensee Paige Haight Hirbert P.O. Box 195	Sykesvi1	le, Md	1 Home & 21784	Chape1		
	Tate be executed // Medical // Medical Examiner fransit the prival-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the part of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ch as cardiac or resp	oratory arrest,		Approximate Interval Between Onset and Death		
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rds, P	w requires that been signed k should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I. 2	3e. Did tobacco		the cause of death?		
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	Sta Registr	•	31. Date filed (Month, Day, Year) 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland / D	Department of Hea Certificate of De		al Hygien	2000	07813
	Physici /Medic		1. Decedent's Name (First, Middle, Last Edg	ar Leo Allende	er	M ₄	te of Death onth D	28 2005	3. Time of Death
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12/1	Maryland	tor	10a. State 10b. County MD Balti	more 10c. City, Town	or Location Essex				10d. Inside City Limits 1 ☐ Yes 2√2 No
3	ith with the M 23e or 28a-f ust be notifie	ai Director	10e. Street and Number 820 Orems Roa	đ	10f. Zip Code 21221		10g. C	citizen of What Cou	ntry?
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-1 show ther than medical Examinar must be rodified at out, the Medical Examinar must be rodified at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 ☐ No Si	nic Origin? (Specify Ye lexican, Puerto Rican, pecify:	etc.)	14. Race - Ameri Black, White Specify: Wh:	, etc.
21215-0036	filed within 72 h Hygiene. ther than "natu nt, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 6th	(e completed)	Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired) aborer	n g most of working		Kind of Business/Ir	
/ / / / C Maryland	ed ala	To Be (17. Father's Name (First, Middle, Last) Leroy Allende		М	Mother's Name (First, aude Ande	erson	,	
	1 and 2 Health a em 27 is ther tra		19a. Informant's Name/Relationship (T) Debbie Copple 20a. Method of Disposition	/daughter	Mailing Address (Street and It 10 Hydropla Disposition (Name of		Balti		
Baltimore,	Page nent o ent: If ury or		1 ☐ Burial 2 🗶 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Removal from State Bayvi	y, crematory or other place) ewCrematory 22. Name and Address of		Ba	ltimore	MD
B	permit. Departr Imports any inji		23a. Parti. Enter the disease, or complishock, or heart failure. List only	formuly Legions that caused the death Legon	300 Mac	ce Ave. B	altimo	neralHom ore MD 2	neofEssex 21221 Approximate
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on o	th. : After to funera		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	ime of jury at work? M 1 Yes		escribe how inju	ury occurred	
Division of	i Cir	Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Loc C <i>it</i> y	cation (Street a y or Town, Stat	nd Number or Rura e)	il Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medicai	29a. Certifier (Check only one) 1 Certifying Physical Certification Physical Certification Phys	sicien: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, da Vor investigation, in my opinion	ate and place, and due n, death occurred at th	e to the cause(s e time, date an	s) and manner as s ad place, and due to	lated. the cause(s)
	To I com	2	29b. Signature and title of certifier	A	29c. License nun			ate signed (Month,	
	Sta	te.	30. Name and address of person who co DY MONON AT 31. Date filed (Month, Day, Year)	mipleted cause of death (Item 23a) (7	Type, Print) Tanklin Squa	are Drive	Bost	iMore, M	28, 2005 bd 21237
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	Physici /Medic		1. Decedent's Name (First, Middle, Last) VERNON AB	BOTT				2. Date of Death Month March	Day	Year	3. Time of	Death M
	Examir		4a. Facility Name (If not institution, give street Harbor Hospital	and number)		Bal	or Location of De	eath	4c. County	of Death		
	Funeral Director		5. Social Security Number 218-22-5954 Usual Residence of Decedent	7. Age (In yrs. Ia 92	st birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birth (Month, Day, JUNE 19)	Year) 1912	Count	ace (State o try) yland	r Foreign
	aryland show	_	10a. State 10b. County		Town or Lo					10	Od. Inside Ci	
	the Market 1	ecto	MD 10e. Street and Number	Ba	altimo	10f. Zip Code		10	g. Citizen of W	hat Caus	XXYes	2 No
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumetic event, If ite Modical Exarcified Trust te notified at once.	by Funeral Director	1 Never Married 2X Married 1	as Decedent Ever in U.S med Forces? □Yes 2∑No Yes, Give ear or Dates:	II	Vas Decedent of I Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	14. Race	- America c, White, e		
21215-0036	vithin 72 ho ne. hen "netul e Modlest	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) ollege (1-4or 5+)	(Give I life. [ent's Usual Occu kind of work done OO NOT use retire	during most of v ad)	working	6b. Kind of Bu		,	
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ylan	Mental Mental Brked o	To Be	Benjamin S. Abbott				Mattie	A. King				
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altimore,	Page tment of tent: ff jury or		1 □ Agurial 2 □ Cremation 3 □ Remov '4 □ Donation 5 □ Other (Specify)	ai ii Oili State	dowrid	ge Mem.	Park 3,	/10/2005 H	Elkridg	e, MI)	
Bal	permit Depar Impor any in		21. Signature of Fun In I Service Licensee		Ga	Name and Addre ry L. Ka 50 Washi	ufman Fi	uneral Home lvd., Elkri	e @ Mead dge, M	owric D 21	dge MP 1075	, Inc.
	Physician /Medical Examiner			s that caused the death. se on each line. My o (a d) Due to (as a conseque	el -	in the mode of dyi		iac or respiratory arres	rt,	2.5	Approximate Interval Bety Onset and D	ween Death
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be delached for use as the burial-transit	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
P.O. Box 6	that the death certifica led by the attending ph detached for use as t	Physiclan/Me	in the past 12 months?	ves, outcome of pregnand Live birth 2 Fetal of Pregnant at time of dea Unknown	leath 3 🗌	Ectopic pregnanc Other (specify) _	у		23d. Date Mont			'ear
	w requires that been signed t should be det	ρ	Part II. Other significant conditions contribution Aspiration Pro	ng to death but not result	ting in the un	derlying cause gn	ven in Part I.		cco use contrib			
l Reco		Completed	Renal Failure					24a. Was an autopsy performe	nd? de	or to com	sy findings a pletion of ca	variable ruse of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	.f.		-		eath (Check only one)				
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Divis	el or Attendi s after death. el Director: A ed in by the fu	Certification;	a Could not be	Place of Injury - At hom building, etc. (Specily)	e, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Numbei State)	or Rural	Route Numb)e <i>r</i> ,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: ○ at	To the best of my knowl in the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tile estigation, in my o	me, date and pla opinion, death oc	ce, and due to the cau curred at the time, date	se(s) and man a and place, ar	ner as sta nd due to t	ted. he cause(s)	
	To Toon	7	29b. Signature and title of certifier Ah Rige Jah	~ MD				614 B40 1	Narch,			5
	10		30. Name and address of person who completed address of person addre	ad cause of death (Item 2	1	Battim	Sic	MD Z	1215			
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 0 9 2005	32 Registrar's Signatu	re Ass	de	,	. 10	161)			

			1 - For State Registrar		State of	Maryland			of Hea of De		nd M	ental Hy	giene Reg. No.	15	7845
	Physic	ion	1. Decedent's Name (First, Mid	dle, Last)						-		2. Date of De		Vari	3. Time of Death
	/Medi		BRIAN OMA		SSETT							March	_ ′	Year 2005	11:45a M
9	Exami	ner	4a. Facility Name (If not institut	оп, give str	eet and numb	oer)		4b. City, 1	fown, or Lo	cation of	Death		4c. Cour	nty of Death	
			15 TENTMILL	_	APT				ESVIL					ALTIMO	RE
	Funeral Director		5. Social Security Number 220-02-7036	6. Sex	A 2□F 7.	. Age (In yrs. Ia		If Under Months	Days F	Under 2	4 Hrs. Min.	8. Date of Birt (Month, Da March	h y, <i>Year)</i> 3 1968	Cour	place (State or Foreign htry) RYLAND
	and *		Usual Residence of Decedent 10a. State 10b. Coun	· · · · · · · · · · · · · · · · · · ·		10c City	Town or Lo	cation							
	f sho	ō		,											10d. Inside City Limits 1 ☐ Yes 2 🛛 No
	the the 288-	ect	MARYLAND BA	LTIMO	RE	F	PIKESV	1 LLE	Cada			1	10- Ciri		
	with 3a or	0		T 7 17 T3	7 D D.								10g. Citizen o		ntry?
	death Tra 2	era	15 TENTMILL 11. Marital Status			ent Ever in U.S	i. 13. V		21208 ent of Hispa	nic Origi	n? (Spe	cify Yes or No-	U.S.7	ace - Americ	can Indian
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Itema 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	1XXiever Married 2 Mi 3 Widowed 4 Divorce		Armed Force 1xxYes 2 If Yes, Give Year or Date	□No	l I	Yes, speci	fy Cuban, M	dexican, pecify:	Puerto F	Rican, etc.)	В	lack, White,	etc.
ŏ	2 hou	ted	15. Decede	nt's Educa	tion		16a. Deced	ent's Usual	Occupation	1			16b. Kind of		
215	should be filed within 72 hours nd Mental Hygiene. marked other then "natural", imatic event, the Medical Exa	Completed	(Specify only high Elementary/Secondary (0-12)		completed) College (1-4	or 5+)	(Give life. L	kind of work OO NOT use	done durin retired)	ng most o	of workir	ng		D001110003111	austry
21	d wit	PO	12th grade		2 yrs		N/A						N/A		
p	al Hy	Be (17. Father's Name (First, Middle	, Last)					18.	Mother's	s Name	(First, Middle,	Maiden Sumi	ame)	
<u>ya</u>	should the nd Ment marked	ဂ္	MELVIN C BAS	SETT						EVA	L B	ASSETT			
Maryland	2 sho and is mu	0 8	19a. Informant's Name/Relation	iship <i>(Туре</i>	, Print)		19b. Mailin	g Address (Street and	Number	or Rura	Route Numbe	r, City or Tow	n, State, Zip	Code)
	1 and 2 Health em 27 i		Eva L. Bassett	/Moth	er	1	1613 ace of Dispos	E. Ma	adisor	n St	., A	pt 10,	Baltin	nore,	Md. 21205
o e	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 △Burial 2 □ Cremation		D	ate	20c. Location	- City or To	wn, State						
Ë	. Pa tmen tant: jury		'4 □Donation 5 □Other	0:	3-15	-05	OWINGS	MILLS	, MD.						
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item any Injury or othe	Signature of Turner Several September 122. Signature of Turner Several September 122. Name and Address of Facility WILLIAM C BROWN 1206 W NORTH AND Several September 1206 W NORTH AND Several September 1206 W NORTH AND Several September 1206 W NORTH AND SEPTEMBER 1206 W NORTH AND SEPTEMBER 1										MUNITY	FUNERA	L HOM	E P.A.
П			23a. Part1. Enter the disease, shock, or heart failure. Li	or complica	tions that cau	sed the death.	Do not ente	r the mode	of dying, su	uch as ca	rdiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		A	120	5								Onset and Death
	/Medical Examiner		resulting in death)		Due to (or	as a conseque	ence of):								year.
	Examiner	L.	Sequentially list conditions,	b	D										
	ted 1sit	nju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (or	as a conseque	ence or):								
	axecu and al-tra	Examiner	that initiated events resulting in death) Last	С.	Due to (or	as a conseque	ence of):								
68760,	icate be executed physician and s the burial-transit														
68	ificate g phys	edicai		a											W
Box	leath certiff attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c.	If yes, outcom	me of pregnand		Ectopic pre	ananov.				23d. D	ate of delive	ry
	at the dea by the att	/sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			t at time of dea		Other (spec					N	lonth	Day Year
P.0	that the		Part II. Other significant condi-	inns/contril	outing to deat	h hut not result	ing in the un	derhina oa	ina muon in	Port I		22a Did to	boood was see	atribusta ta th	
Vital Records,	law requires that the death certii as been signed by the attending 2 should be detached for use a	ted by	61 2	lle	VING	- Sut Hot 163un		uerrying cat	ase given in	raiti.	_		es 2 No		ably 4 D nknown
ecc	has be	Completed	- XMAMI	7								24a. Was a			osy findings available
<u> </u>	Th ate pag	Con	Michile									perform		death?	npletion of cause of
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?						26.	Place of	Death	(Check only	Θ)		
of \	Physic this c	2	1 ☐ Yes 🕩 No	Hos	pital: 1 🗌 Inpa	atient 2 🗆 Ef	R/Outpatient	3□ DOA	Other: 4	☐ Nursi	ng Hom	e 5 Deside	ence 6 🗆 Ot	her (Specify)
Ē	fter me	on:	27. Mann of Death 1 Datural 5 ☐ Pend	ng	28a. Date of I. (Month,	njury 2 Day Year) 2	8b. Time of injury	280	c. Injury at Work?		28	3d. Describe ho	w injury occu	rred	
Sic	Attending ir death. ector: After by the fune	cat	2 Accident inves	igation notes				М	1 TYes	2 🗆 No					
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification;	4 Homicide deter		building,	Injury - At hom etc. (Specify)	e, farm, stre	et, factory,	office		28	3f. Location (St City or Town	reet and Num n, State)	ber or Rural	Route Number,
_	Hospital Puneral Funeral litely filled		29a. Certifier 1 Cartify	ng Physici	an: To the be	st of my knowl	edge, death	occurred at	the time, da	ate and r	place ar	nd due to the ca	ause(s) and m	annor ac ch	atod.
	the the the	Medical	one) 2 Madica	Examiner	On the basis	s of examinatio	n and/or inve	estigation, ir	n my opinior	n, death	occurred	at the time, d	ate and place	and due to	the cause(s)
	To To	-	29b. Signature and title of certific	1 1	Mila	0,1	47	29c. l	License nun	nber 2 n	10	2	9d. Date sign	d (Month,	Day, Year)
j	1		10MU/	4/1	VIII	1/1/	//		11/2	20/	_		9/	1/1	2
Ü	511		30. Name and address of person	who comp	letter cause o	of death (Item 2	(Type, P	rint)	1011	1011	1	1 2	37/1/2	MAN	21718
	Sta	te	31. Date filed (Month, Day, Year		Regi	strar's Signatur	· foo	401	WU	VA	14	1	(الا المالم	114	-10YU
	Registr	ar	MAR 0 9	2005	Bloke	a st	A DE								

attent known as Shormon Brown Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Brown March 3:13 2 2005 hormon /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** of Baltimore Sinai Hospital Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□ M 20 F 214-78-313 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 THES 2 No ltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3916 21 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 DNever Married 2 Married þ Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) House Keeping The Shenaton Comp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H 7 Is marked ot Brown, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Martha Baltimine MDZ1215 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 8/05 * 4 ☐ Donation 5 ☐ Other (Specify) Zion Cem 21. Signature of Funeral Service License Service, P. A. 22. Name and Address of Facility
Hans F. Close
5126 Belown Belain Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) days **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has autopsy performed? res 2X No After this certificate t 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death

1 Natural

2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred of or Attending Parter death. 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 \ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, RES - 000 March 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore Patrice Moore M.D. Sinni

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registras Signature

樹香 0 9 2005▶

rre.	y brown		State Unpend Item 2	State of M 3a&27 per	aryland/Depa r me G841	artment of He Tilicate of L	ealth and I Seath	Mental Hygio	ene 3. No.2 0 0 5	07847		
	Physicia		1. Decedent's Name (First, Middle, Last)	WD				2. Date of Death Month March	Day Year 04, 200	3. Time of Death 5 20:50 M		
	/Medic Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or I			4c. County of Dea	th		
-			2518 Druid Hill Ave		tment 5 (In yrs. last birthday)	Balti If Under 1 Year	More If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign		
7	Funeral Director			[M 2□F	44 Yrs.	Months Days	Hours Min.	(Month, Day, 1)	(ear) Co	MD MD		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	Maryi a-f sho	tot	MD N/A		I	3altimor	(Y			1 K∏ Yes 2 ☐ No		
	death with the Maryland ma 23a or 28a-f show Fraust be recitified at	Funeral Director	10e. Street and Number 2518 Druid Hill,	Avenue	Apt 5	10f. Zip Code	217	10	g. Citizen of What C	ountry?		
	death	nerai		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whi			
036	be filed within 72 hours after death with the Marylan Hygiene. At Hygiene. At Hygiene. At the Marylan to that then "natural", or Itama 23a or 28a-f show event, the Marylan Exercit at resist be restified at	þ	1 ☐ Never Married 2 反 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊗Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🔀 No	Specify:	, riodii, oto.,	Specify: B			
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73	i ba file ntal Hy ad othe sevent,	Be	17. Father's Name (First, Middle, Last) BOOKER T. BROW					ie (First, Middle, Milta Brow				
aryl	s 1 and 2 should ba if Health and Mental I itam 27 is markad or other traumatic sve	္			19b. Mailir	ng Address (Street ar			HELD SECTION AND ADDRESS OF THE PARTY OF THE	Zip Code)		
	ss 1 and 2 of Health a itam 27 is other tra			n Brown		The second second	d Avenu			21207		
Jore	agas 1 nt of H : If itan		1 ⊠ Burial 2 ☐ Cremation 3 ☐ P									
altimore,	parmit. Pagas Department of Important: If it any injury or once.	ı	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), Traheme L. Green Brown Wife 4402 Kathland Avenue Baltimore MD 21 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Constitution of Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name, and Address of Facility 23. Name, and Address of Facility 24. Name, and Address of Facility 25. Name, and Address of Facility 26. Name, and Address of Facility 27. Name, and Address of Facility 28. Name, and Address of Facility 29. Name, and Address of Facility 20. Pike Baltimore MD 2122									
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			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	e cause on each li	d the death. Do not ent ne. ge Renal Di		, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death		
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П	and I-transit	Examin	that initiated events									
8760,	be exician ician buria	ai Ex	resulting in death) Last	Due to (or as	a consequence of):							
687	tificate ig phys as the	ledicai										
S. Box	raquires that the death certific aen signad by the attending p nould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
, P.O	es that th ignad by be detact	by Phy	Part II. Other significant conditions cor	tributing to death b	out not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute t	o the cause of death?		
ords	v raquires baen sig should be							1 ☐ Yes	2 2 No 3□P	robably 4 Unknown		
S	e law has b	Completed						24a. Was an autopsy	prior to death?	utopsy findings available completion of cause of		
The second of th										5 2 NO		
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28d. Describe how injury occurred Work? 1 1 Natural 5 Pending 28d. Date of Injury 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 4 Nursing Home 5 Hesidence 6 X (ther (Specify)) 5 Nursing Home 5 Hesidence 6 X (ther (Specify												
Division	To the Hospital or Attanding within 24 hours after death. To tha Funeral Diractor: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inbuilding, et	jury - At home, farm, str c. (Specify)			28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,		
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	Medical C			of my knowledge, deat if examination and/or in ated.							
	To the within To the comple	Me	29b. Signature and title of certifier	Δ		29c. License		290	d. Date signed (Mon	th, Day, Year)		
1			Mounte ()	relson	llhin	OC	ME 	1	March 05,	2005		
	9		30. Name and address of person who co	mpleted cause of o		Print) 111 Pe	nn Stree	et Baltin	more, Mary	land 21201		
					ar's Signature							

amend item/12, perfh, 6841, 3/9/05 TT State of Maryland / Department of Health and Mental Hygiene 0 5

			1 - State Registrar		, , , , , , ,	Cer	tificate	of De	eath	iorital riy	Reg. N		10	0/848
	Physic	ion	1. Decedent's Name (First, Middle, La	st)				_		2. Date of De.	ath			3. Time of Death
	/Medi		CHARLES JAMES BOR	MUTH						MAR.		ay ~2005	Year	10:30 P ^M
	Exami	ner	4a. Facility Name (If not institution, giv	e street and number)			4b. City, To	own, or Lo	cation of Death			c. County		110.00
			Gilchrist Center					Tows	on			Balt	imor	е
	Funeral Director		5. Social Security Number 6. S 717~07~9810 X Usual Residence of Decedent	6ex 7. Age	(In yrs. last b	Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da May 6,	y, Year	r)	9. Birthp	lace (State or Foreign htry) yland
	land ow		10a. State 10b. County		10c. City, Tov	vn or Loc	ation						1	0d. Inside City Limits
	he Man 28e-f sh	Director	Maryland Baltim	ore		Ba]	ltimor		unty					1 ☐ Yes 2 🖔 No
	ath with 1	ral Dir	8339 Arbour Stati	on Way			10f. Zip C		L234			itizen of W USA	hat Cour	try?
980	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Itams 23e or 28e-f show event. Ite Modical Exertiner must be ricitized at	by Funeral	11. Marital Status XX I Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 12 Yes 2 2 3 If Yes, Give Year or Dates:	le		/as Deceder Yes, specify ☐ Yes X2√		nic Origin? (Spe lexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	-		, White,	an Indian, etc. ite
21215-0036	C 2	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		(Give k	ent's Usual (aind of work O NOT use	done durin	n g most of worki	ing	16b. I	Kind of Bus	iness/Ind	dustry
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b	al Hygie I other vent, II	Be	17. Father's Name (First, Middle, Last,		,			18.	Mother's Name	(First, Middle,				
Maryland	ould be i Mental I warked o	To	Joseph Bormuth					En	ma Schm	nuff				
ar	2 sho and h ia ma		19a. Informant's Name/Relationship (Type, Print)	198	o. Mailing	Address (S	Street and	Number or Rura	I Route Numbe	r, City	or Town, S	tate, Zip	Code)
_	alth and art.		David A. Wyatt (N	ewphew)	4	041	Firef	ly Ct	. Ellic	ott Cit	υ.	Md. 2	21042	2
ore	of He of He fiten		20a. Method of Disposition	Demoust from St. d.	20b. Place o	f Disposi		of		Date	_	ocation - C		
Baltimore,	it. Pag irtment irtant: I njury o		XXBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific	0	Most H	- T			Cem. 3-7		Bal	Ltimor	re, N	Maryland
Ba	permit. Pages 1 a Department of He. Important: If item any injury or othe	kz - 1	21. Signature of Funeral Service Licer	ISBB LOCATION		La 74	ssahn 01 Be	Address of Fune lair	ral Hom Rd. Bal	e timore,	Md	212	36	
			27a Partit Friter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do	not enter	r the mode o	of dying, su	ich as cardiac o	r respiratory ar	rest,	. 616	.00	Approximate
	Pnysician	١,	Immediate Cause (Final disease or condition			0 1	en	el d	ILEAC	P				Interval Between Onset and Death
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	Examiner		Sequentially list conditions		certe								Į.	year
	P #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or s	consequence	of):								0
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
68760,	ertificate be executed ding physician and se as the burial-transit			Due to (or as a	.consequence	of):								
587	ficate phys s the	Medical		d										
.O. Box	the death c y the attend iched for us	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	🛚 🗆 Fetal death		Ectopic pregi Other <i>(speci</i>					23d. Date Mont		y Day Year
Ţ	s that ned b deta	by PI	Part II. Other significant conditions of	ontributing to death but	t not resulting in	n the und	serlying caus	se given in	Part I.	23e. Did to	bacco	use contrib	ute to the	cause of death?
rds	The law requires that ate has been signed b bage 2 should be deta	ed b	peripheral	VASCUL	av di	J e 4	tse,	 		1 🗆 Y	es 2	(2) No 3	☐ Proba	bly 4 Unknown
ecc	law requ as been 2 shouk	plet	congestive)	east of	arla	il				24a. Was a		24b. We	ere autop	sy findings available
Vital Records,		Completed	0							autops perfori 1 Yes	sy med? 2 ATN o	de	or to com ath?] Yes :	pletion of cause of
<u> </u>	ician certif ector	Be	25. Was case referred to medical examiner?	Hospital:					Place of Death	(Check only on	18)			
of	Phy ratio	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	□ ER/Outpatient 3 □ DOA □ Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) □ Other (Specify							Hospice			
Division	ial or Attends after death blirector:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, stree	et, factory, of	ffice	2	28f. Location (St City or Town	treet ar n, State	nd Number a)	or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best of liner: On the basis of e and manner state	examination an	death o	occurred at t stigation, in	he time, da my opinior	ate and place, a	nd due to the cand at the time, do	ause(s)) and mann d place, and	er as sta d due to	ted. the cause(s)
	To t To t	2	29b. Signature and title of certifier	10				cense nun				te signed (
)	(X)		A Anther	y liky	FINS	_	10-	252	05	Balto	m.	Avol	4.	2005
	13,		30. Name d address of person who	GBMC	670		N. Ch	Incl	s st.	Balto	. 67	11	2/2	201
*	Sta Registr	- 1	31. Date filed (Month, Day, Year) MAR 0 9 2005	32. Registrar	's Signature	and!	,							

Bormutt, Charles 3/3/05@3830

			For State	State of Marylar	nd / Departm <i>Certific</i>			•	0000	nuae o h list g along g
			Registrar 1. Decedent's Name (First, Middle, Last)		Certific	ale or	Dealli	2. Date of De	Reg. No.	3. Time of Death
ı	Physici		Gilbert Marvin	Rint				Month (Day 1 Yea	~ 1000 m
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. C	ity, Town, o	or Location of De		4c. County of De	- 0,
	CXUITIII		Morts By	mdel Ho	spital	3/1	~ Bi	~nile	Anni	Brundel
	Funeral Director		5. Social Security Number 6. Sex 218-18-5190	M 2□F 7. Age (In yrs. 81	Yrs. Mont	hs Days	Hours M	in. (Month, Da	0/1923	Firthplace (State or Foreign Country) MD
Ser	B		Usual Residence of Decedent						, 1323	
	show	ក	10a. State 10b. County		ty, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	Director	MD Anne Ar 10e. Street and Number	undel P	asadena	Zip Code			10g. Citizen of What	
	with Sa or	Ö	8589 Bay Road		101.	2112	2		U.S.A.	oodiniy.
	ns 2	era	***************************************	12. Was Decedent Ever in U	I.S. 13. Was De			(Specify Yes or No erto Rican, etc.)		merican Indian,
98	be filed within 72 hours after death with the Maryland tal hygiene. id other than "natural", or itams 23e or 28e-f show other than "natural", or itams 23e or 28e-f show event, the Madical Exertil et mail ke molified at	y Funeral	1 Never Married 2 Married	Armed Forces? 1 Xi Yes 2 No 19	43-	specify Cub. s 201 No		erto Rican, etc.)	Black, W	hite, etc.
21215-0036	hours tural',	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 19	40				<u> </u>	White
5	in 72 n na	piete	(Specify only highest grade	completed)	16a. Decedent's U (Give kind of life. DO NO	work done	during most of t	working	16b. Kind of Busines	ss/industry
212	d with	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Departm	ent	Superv	isor	MTA	
	tal Hygied other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	, Maiden Sumame)	
Maryland		Tof	John Blunt					sta Litz		
lar	2 short and is m		19a. Informant's Name/Relationship (Type						er, City or Town, State	
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Evelyn Blunt/Wi		8589_B Place of Disposition (oad, P	asadena,	, MD 2112 20c. Location - City	
סר	0 0		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, crematory	or other pla				
Baltimore,	permit. Pag Department important: I any injury o		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service License						Glen Bur	nie, MD 1 Home, PA
Ba	permit. Departm Importa any inju		Jeal Son						sadena, N	
	9		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deal						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cause on each line.	chen	c (Cand	Jo my	north	Onset and Death
	/Medical		resulting in death)	Due to (or as a consec				1	1	-
	Examiner		Sequentially list runditions							
7	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	juence of):					
V	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a consec	quence of);					
8760,	e be e siciar e burit	dical E								
9	tificate g physi as the l	ledic							1	
ŏ	leath certific attending p	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		c pregnancy	v		23d. Date of d	
of Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of c			,		Month	Day Year
7	that the de ed by the a detached t	Phy	Part II. Other significant conditions cor	tributing to death but not res	sulting in the underlying	no cause on	en in Part I	23e Did t	obacco use contribute	to the cause of death?
ds,	uires tha signed Id be det	Completed by	5 7006	. e		.g cacco g				Probably 4 Nnknown
COL	w requir been s should	iete						24a. Was	an 24h Were	autonsy findings available
Re	The law ate has page 2 s	dwo						autor perfo	psy prior t ormed? death	autopsy findings available o completion of cause of ?
ta		0	25. Was case referred to medical				26. Place of 0	1 Yes		95 213(NO
Į V	× 5 5	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 2 patient 2	ER/Outpatient 3	DOA Oth	er: 4 🗆 Nursin	g Home 5 ☐ Resid	dence 6 □Other (S)	pecify)
	fe fe	ü	27. Manner of Death Natural 5 Pending	28a. Dáte of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at rk?	28d. Describe I	how injury occurred	
Sio	tendi leath. Ior: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	Di Di di	М		Yes 2□No	00/ 1		
Division	for At after of Direct	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)	tory, office		28f. Location (Street and Number or wn, State)	Rural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 45 Certifying Phys	sician: To the best of my knowner: On the basis of examina	owledge, death occur	red at the tir	me, date and pla	ace, and due to the	cause(s) and manner	as stated.
	the H nin 24 the F nplete	Medical	one)	and manner stated.	ation allow investiga					
	To To		29b. Signature and title of certifier		7	1) i L C	> () ()		29d. Date signed (Mo	7 10 C
7			30. Name and address of person who co	mpleted cause of death (lter	7 23a) (Typo Briet)	778			V3 10 T1	2000
	5+1		KOFI BUA	7 = 7	O THOU	W30	n (a)	JV: 1 5	Man R	(Ty brown
	Sta Regist		31. Date filed (Month, Day, Year)	32. Recentrar's Signa	ature 4	de	*			,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

For State Ragistrar

07850

			1. Decedent's Name	e (First, Middle, Las	t)		_			2. Date of I				3. Time of Death
	Physici /Medi				Kevin I	Duane Ba	1k	00		March	14,2	005	Year	6:15 A
	Examir		4a. Facility Name (II	f not institution, give	street and number)			4b. City, Town, o	or Location of Dea			tc. County	of Death	
			3800 (Chestnut	Road			Middl	e Rive				Ltim	ore
	Funeral		5. Social Security N			e (In yrs. last birtho	7.	If Under 1 Year Months Days	If Under 24 Hi	n (Month	Birth Day, Yea	ur)	9. Birth	plece (State or Foreigntry)
	Director		217-58-5	7024	M 2□ F	46 Yrs	5.			June	5,19	58	New	Jersey
	pug *		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town o	r Loc	ation						10d. Inside City Limit
	sho	ō	MD	Baltim	ore			iddle	River				İ	1 □ Yes 2 ☑ N
	28a-1	Director	10e. Street and Nun					10f. Zip Code		·	100.0	Citizen of V	Mhat Cou	
	with	ក់		Chestnut	Road			2122	.0		_	JSA	Wilat Cou	ind y r
	within 72 hours after death with the Maryland ene. than "naturel", or tems 23a or 28a-1 show the Modical Examiner must be notified at	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. W		Hispanic Origin?	(Specify Yes or I	No-	14. Rac	e - Ameri	can Indian.
_	fter o	Ξ		ed 2 X Married	Armed Forces? 1 ☐ Yes 2 ☑ 1		II	Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)			k, White,	
	urs a	by	3 Widowed		If Yes, Give Year or Dates:		1	□Yes X XNo	Specify:			Specify	Whi	te
5	2 ho	Completed	(\$000	15. Decedent's Ed		16a. D	ecede	int's Usual Occup	pation	nekina	16b.	Kind of Bu	usiness/In	dustry
Ž	thin 7	ple	Elementary/Second		College (1-4or 5				during most of w	orking	U	Jnior	า	
V	gien gien er th	000	12th			E 1	.ec	trican	,			oca]		
	be filed withintal Hygiene. Id other than event, the M	Be (17. Father's Name (ame (First, Midd -			ne)	
<u>a</u>	should be nd Menta i marked umatic ev	2	Steve	en Balbo)				Haze.	l M. Ha	arwc	od		
2	2 sho and is mu			ame/Relationship (7		19b. M	_		and Number or I					-
≥,	s 1 and f Health Item 27 other tr			Balbo /	wite		_		stnut 1	DATE OF THE PARTY	_			
	Pages 1 are neut of Hear nut: If Item iry or othe				Removal from State	1	crema	ition (Name of atory or other pla ofFaith		7 / 0 5		Location. Lltin		own, State MD
	permit. Pages Department of I Importent: If Its any injury or o		21. Signature of Fu	neral Service Licen		[]	22.	Name and Addre	ess of Facility	Connell	LyFu	nera	alHo	meofEsse 21
	40100		000 000	ung (June Dilications that caused	ery !		ou Mac	e Ave.	Baltin	nore	MD	212	
			snock, or near	rt failure. List only o	one cause on each li	10.								Approximate Interval Between Onset and Death
	Physician		Immediate Cause (disease or condition resulting in death)	n	a. Acu-	TE MY	0	CARDI	ol i	MARC	Tie	رم		
	/Medical Examiner	ш	issuming in ocum,		Due to (or as	a consequence of):	_		OL I			,		
		<u></u>	Sequentially list con	nditions,	b. Due to for as	a consequence of):	-/ E	NSIVE	CAK	DIOVA	SCU	LAR	0.5	9-1
	ted	in in	Cause. Enter Unde Cause (Disease or	rtying	2 (
	xecu al-tra	Examiner	that initiated events resulting in death) L		c. Due to (or as	a consequence of):					_			
00/00	certificate be execut iding physician and ise as the burial-trar				4									
00	ficate phy:	edic			d									
XOD	eath certificate be executed attending physician and for use as the burial-transit	an/Medical	IF FEMALE: 23b. Was decedent	t oregnant	23c. If yes, outcome		_					23d. Dat	e of deliv	erv
_	death of atten	ਹ	in the past 12	months?	1 Live birth 4 Pregnant at			ctopic pregnanc Other (specify) _	у			Moi		Day Year
ġ	the c y the ached	Physi	9 Unknown		9□ Unknown									
T	law requires that the de as been signed by the 2 should be detached	by P	Part II. Other signif	icant conditions co	ontributing to death b	ut not resulting in th	e und	derlying cause gn	ven in Part I.	23e. Dio	tobacco	use conti	ribute to t	he cause of death?
cords,	quire; n sig									1 🗆	Yes	2 🗆 No	3 🗆 Prot	pably 4 Unknown
	w rec	ompleted								24a. Wa	ıs an	24b. V	Vere auto	psy findings available
T T	0 - 0	E C								per	opsy formed?		leath?	impletion of cause of
Vilai	i lcien: Th certificate rector, pag	Ö	25. Was case refer	red to medical		**			36 Place of D	1 ☐ Yes eath (Check only		lo 1	Yes	2 No
>		O	examiner?		Hospital:	ent 2 ER/Outpa	tient	3□ DOA Oth	ner: 4 Nursing			6 □Oth	or /Specif	(a)
5	Phys or this oral di	-	27. Manner of Death		28a. Date of Inju	ry 28b. Tim	e of	28c. Injui	ry at	28d. Describe				y)
VISION	ding f th. : After funer	tion	1 ☑Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	y Year) Inju	ry		rk?]Yes 2 ☐ No					
2	Atter dea actor	fica	3 🗌 Suicide	6 Could not be determined	28e. Place of inj	ury - At home, farm	stree	et, factory, office		28f. Location	(Street a	and Numbe	er or Rura	al Route Number,
5	To the Hospitel or Attending Pwithin 24 hours after death. To the Funerel Director; After to completely filled in by the funera	Certification:	4 🗌 Homicide		building, et	c. (Specify)				City or T	own, Sta	110)		
	spite hours inere		29a. Certifier	1 Certifying Ph	sician: To the best	of my knowledge, d	eath (occurred at the ti	me, date and plac	ce, and due to th	e cause(s) and ma	nnerass	tated.
	ne Ho n 24 l ne Fu	edical	(Check only one)	2 ☐ Medical Exam	iner: On the basis of and manner sta	examination and/o	r inve	stigation, in my	opinion, death occ	curred at the time	, date a	nd place, a	and due to	the cause(s)
	Vithi Vithi To th	ž	29b. Signature and,	title of certifier	na n.o.			29c. Licens				_		Day, Year)
	^-		DON	TO A. V	INCAS J	2 1.0.		Do	017148	7	3	-0	7 - a	5
	1, 2		30. Name and addre		completed cause of d		pa, P	rint)	P 1		> / .			
	\		470	HARTZ	TILD FLO.	21 50	47	1170126	, Jergi	- 7 1 4/	-14			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

MAR 0 9 2005

			1 - For State of Maryland / Department of Hea	ooth	2008 07851
			Decedent's Name (First, Middle, Last)	2. Date of De	
	Physici /Medic		Anna F. Billips	Month 03	Day Year 07 05 6:150 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	cation of Death	4c. County of Death
			Trank in Square Hospital Center Roseda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	f Under 24 Hrs. 8. Date of Bir	th Baltholae (State or Ferriga
	Funeral Director		411-48-3354 1 M 2 F 75 Yrs. Months Days F	Hours Min. 8. Date of Bir (Month, Da April 7	th Ly, Year) 1,1929 Sirthplace (State or Foreign Country) Virginia
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		
	Maryia f sho	ō	MD Baltimore Middle R	iver	10d. Inside City Limits 1 ☐ Yes 2% No
	r 28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	th with		82 Torque Way 2	1220	USA
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
36	urs aft	by F	1 ☐ Never Married 22 Married 1 ☐ Yes 2 5 No If Yes, Give 1 ☐ Yes 2 1 No S 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify:	Specify: White
5-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done duris	in most of working	16b. Kind of Business/Industry
الا 2121	vithin ne. han "	mple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	ng most of working	our home
25	filed within 72 hours after death with the Maryland Hygiene Hygiene than "natural; or Itams 23a or 28a-f show ant, Ita Medical Eracine must be codified at		9th	3. Mother's Name (First, Middle,	OWN home
lan	2 should be filed with and Mental Hygiene. Is marked other tha aumatic avent, It etha	To Be	Elbert Woods	Hattie M	Ae George
Alary	2 short		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and		er, City or Town, State, Zip Code)
$ _{\mathrm{pS}}, \mathcal{H}n\mathcal{K}$ more, Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healint and Mental Hygiene. If Healint and Mental Hygiene "natural", or Itams 23a or 28a-f show titms 71 is marked other traumatic avent, I'm Meuloul Eracin er mast be rediffed at		Bruce B. Billips/husband 82 Torque War 20a. Method of Disposition (Name of	ay Baltimore	MD 21220
- On	Pages nent of P int: if its iry or of		1 Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) HollyHillCemete		
	# 문문를 .		21. Signature of Funeral Service Licensee 22. Name and Address o	of Engiller	
, , <u>m</u>	permi Depa Impo any iu		R. Terry Connelly 300 Mac		FuneralHomeofEssex
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.	such as cardiac or respiratory as	rrest, Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition a. HUPOXEMIA		Onset and Death
	Examiner		Due to ((of as a consequence of):	1	
		ner	Sequentially list conditions, in any, loading to immodiate cause. Enter Underlying Cause (Disease or injury		
A	ecuted and transi	Examiner	triat initiated events C.		
8760,	be executed sician and burial-transit	lical E	Due to (or as a consequence of):		
687	ificate I g physi as the b	edic	d.		
Box 6	leath certifica attending ph	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
O. E.	ne dea the at hed fo	hysiclan/Mec	In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown		Month Day Year
P.O.	res that the digned by the	۵.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I, 23e. Did to	obacco use contribute to the cause of death?
rds	w requires been sign should be	ed by	End Stage clementia	1 🗆 1	res 2□No 3□Probably 4⊅Unknown
၀၁ခ	law re as bee 2 sho	ompleted		24a. Was	an 24b. Were autopsy findings available
Ä	The la	Сош		perfo 1 ☐ Yes	ssy prior to completion of cause of med? death?
Vita	ysician: Th nis certificate director, pag	o Be	examiner?	6. Place of Death (Check only o	
of	y Phys er this eral di	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	4 Nursing Home 5 Resid	dence 6 (Other (Specify) now injury occurred
io	ttanding I death. ctor: After / the funer	atlo	2 Accident investigation M 1 Yes	: 2 □No	
Division of Vital Records,	I or Attanafter deatl	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Rural Route Number, vn. State)
	spital ours a neral [al Ce	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, of	date and place, and due to the	cause(s) and manner as stated
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 124 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	edic	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner stated.	on, death occurred at the time,	date and place, and due to the cause(s)
	To Te With To I	Σ	29b. Signature and title of certifier 29c. License nu		29d. Date signed (Month, Day, Year)
	ń		MA DS?	3462_	31710
			30. Name and address of person who completed cause of death (Item 2 a) (Type, Print) DV MAY MUNCSCS 4DOX FYRAKIN SILL	are Dowe Pro	3/7/00 Himore, MD 21237
	Sta	0	31. Date filed (Month, Day, Year) MAR 0 32. Registrar's Signature	MI PELVE ELL	
	Registr	ar	MATERIAL STREET	1	

		•	For State Registrar	State of Ma	aryland / [•	artment of H rtificate of L		, ,	giene Reg. No.	05	07852
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)	1.				2. Date of Dea	ath Day	Yeer	3. Time of Death
	Physici /Medic		Margar		rbi				Magth —	06	05	8 H M
	Examin	er	4a. Facility Name (If not institution					Location of Death)	4c. County		
			Anne Arundel 5. Social Security Number		ter e (In yrs. last bir	thday)	Annapo If Under 1 Year	L1S If Under 24 Hrs.	8. Date of Birt		9. Birtho	Ide L lace (State or Foreign ltry)
	Funeral Director		050-07-8919	1 □ M 2 □ XF		Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Oct. 8,	y, Year) 1913		York
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Le	postion				1	0d. Inside City Limits
	Aanyla I show	5	,	Arunde1	Anna							1 Yes 2 TYP
	the h	rect	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?
	h with	<u>a</u>	1809 Viewtop	Court			2140	01		USA		
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced	If Yes Give			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	- 14. Rad Bla Specif	ce - Americ ck, White, y- Wh	
21215-0036	"na	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	it's Education st grade completed)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of wor.	king	16b. Kind of B	lusiness/Inc	dustry
	should be filled withlind Mental Hygiene. s marked other than umatic event, ILE III	Соп	12		Ac	lmir	nistrative				rance	<u> </u>
and S	ntal H ed oth	Be	 Father's Name (First, Middle, Ferdinand Koen 					18. Mother's Nan	et Bedna		πe)	
Maryland	d 2 should be th and Mental (7 is marked of treumatic ev	ှင	19a. Informant's Name/Relations		19b	. Mailir	ng Address (Street a				State, Zip	Code)
	12 12 16 17		Kenneth W. Bar		1	809	Viewtop	Court, A	Annapoli	s, MD 2	1401	
altimore,	of Healt of Healt litem 2		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	2 Demoval from State	20b. Place of cemeter	f Dispo	sition (Name of matory or other place	9)	Date	20c. Location	- City or To	wn, State
Ĕ	Page ment ent: It ury o		'4 □ Donation 5 □ Other (S		Metro		matory			Baltimo	re, M	D
Ball	permit. Pages 1 a Department of He importent: If item any injury or othe		21. Signature of Funeral Service	}			Name and Addres Hardesty 12 Ridge	ly Avenue	Annap	olis, M	D 214	.01
				complications that caused tonly one cause on each lin	the death. Do	not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,	- 1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	PS15							
d	Examiner			Due to (or as	a consequence	of):	-12/ 120	Acia	101	C + 10	e l	
	100	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	ofy:	rial ins	UNIC MEN				
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90,	icate be executed physicien and s the burial-transit	EX	resulting in death) Last		a consequence	ot): b,	Matin	1				
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Box (res that the death certifitisigned by the attending to be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				ate of delive	ory Day Year
ď.	s that ined b e deta	by Pł	Part II. Other significant conditi					en in Part I.	23e. Did to	obacco use con	tribute to th	ne cause of death?
g	w require been sig should b		Right Kine	e Prostheti	cintec	tro			1 □ Y	res 2型No	3 Prob	ably 4 Unknown
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Vita	Physician: this certifica	Be	25. Was case referred to medica examiner?	Hospital:			othe Othe	26. Place of Dea		-		
o	Physical direction	To.	1 ☐ Yes 2 No 27. Manner of Death	1 2/npatie		tpatier	IL 3 DOA	4 Nursing n	ome 5 Resid			/)
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Division of Vital	ol or Attense effer death i Director:	Certification;	3 Suicide 6 Could determ		ury - At home, fa c. (Specify)	ırm, str	eet, factory, office		28f. Location (5 City or Tow		per or Rura	I Route Number,
	To the Hospitel within 24 hours of To the Funarei I completely filled	Medical C		ng Physician: To the best Exeminer: On the basis of and manner sta	f examination an							
	To the To the comp	X	29b. Signature and title of certifie	27			29c. License	number		29d. Date signe	d (Month, i	Day, Year)
/	11	2	10	Emster, 17			D57	019		Marc	ch 6	,2005
G-	J(0		30. Name and address of person Keth Damsk 31. Date filed (Month, Day, Year,	ler, mo	leath (Item 23a) 13901J Sar's Signature	-	/	sland k	Poud Ar	mapol	3,0	413 21401
	Sta Regist			9 2005	www. Jr		5.65					

Stefan Bell 05-01551 dl

Physici		Decedent's Name (First, Midd	dle, Last)			_				2. Date of De	eath Da	- 4	ear	3 Time o	Deat
/Medic		Stefan			Be11					March		2005	ear	8:57	A
Examin		4a. Facility Name (If not institution	on, give street and num	iber)				Location of		HOLUII		. County of	Death		
		Maryland House	of Correc	tions .	Annex	Jess					Ar	ne Ai	runde	e1	
Funeral		5. Social Security Number		7. Age (In yrs.	. last birthday)	If Under Months		If Under 2 Hours	Min	B. Date of Bir (Month, Da	rth ay, Year)	9	9. Birthpla	ace (State o	or For
Director		086-62-2645 Usual Residence of Decedent		2	27 Yrs.					Dec. 7	, 19	77 W	lashi	ngtor	1,
A ==		10a. State 10b. Count	у	10c. Ci	ity, Town or Lo	ocation							10	d. Inside C	ity Lir
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380	<u>e</u>	2515 Symphony	y Lane				21054	4				USA			
naturel', or items 23a or 28a-f show idical Ezatul nermual be indiffed at	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.				in? (Spec	ify Yes or No		14. Race -			
or Ite		1 ☐ Never Married 2 📉 Ma	rried 1 ☐ Yes	2 X No		1 Yes 2		Specify:	, rueno A	can, etc.)			White, e		
irel',	d by	3 ☐ Widowed 4 ☐ Divorce	d Year or Da	tes:		12.165 4	21.1V	эрөспу.				Specify:	WI	ite	
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then	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOT us					77 - 4				
Hygi Sther	e C	17. Father's Name (First, Middle	, Last)		vere	rinar			's Name (First, Middle		erina Sumame)			
ental ked c	To B	Robert Bell							. `	Willi					
i of Health and Mental Hyglene. If Item 27 is marked other then " or other treumatic event, the Mec	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address	(Street ar			Route Numb		or Town. St.	ate. Zio (Code)	
alth a 27 ls r tre		Renee' J. Bel	Ll (Wife)							brill	•				
of Health fitem 27 r other tre		20a. Method of Disposition		20b. I	Place of Dispo				Da	-		ocation - Ci		n, State	
nt: If		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (iale	iphany				- 12-2	005	Ode	nton,	MD		
Depertment of Importent: If I any injury or ouce.		21. Signature of Funeral Service	e Linensee		The second second second	2. Name and	d Address	of Facility	,			ii coii ș	TID		
8 5 8		Hardesty Funeral Ho 12 Ridgely Avenue, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res								lome,	P.A.	c MD	214	01	
Medical aminer		disease or condition resulting in death)		ic (he		intoxi	, ,							Interval Bet Onset and I	e weer Deat
aminer	al Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last	bDue to (c		quence of):	intoxi	, ,			-				interval Bet Onset and I	weer
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	414	1 - State Amend Item Registrer 1. Decedent's Name (First, Middle)					2. Date of I		Year	3. Time of Death
Physici Medio/		KAREN BRANCH					March	-	005	6:32 P M
Examin	ıer	4a. Facility Name (If not institution			4b. City, Town, o		Death	4c. 0	County of Death	
uneral		Maryland Genera 5. Social Security Number		e (In yrs. last birthday	Baltimo		4 Hrs. 8. Date of i	3 irth	N/A 9. Birth	iplace (State or Foreigi
irector		216 90 8681	1□M 2√2F	41 Yrs.	Months Days	Hours	Min. JULY th , J	Pay, 196.	3 MARY	ĽÄND
A T		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	.ocation					10d. Inside City Limits
a-f show	tor	MD I	N/A	BALTIMORE	3					1 X Yes 2 □ No
:3a or 28a-f show st be notified at	al Director	10e. Street and Number 717 N. MILTON A	УЕ.		10f. Zip Code 21205			1	en of What Cou	intry?
al', or itams 23a Exteril et cust	by Funeral	11. Marital Status 1	12. Was Decedent Armed Forces? ed 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2 🛣 No	Hispanic Origi an, Mexican, Specify:	n? (Specify Yes or Puerto Rican, etc.)		4. Race - Ameri Black, White Specify:	
nd other then "neturel", event, the Musical Ex	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th	's Education it grade completed) College (1-4or t		edent's Usual Occup e kind of work done DO NOT use retired NE OPERAT		of working		d of Business/Ir	
markad othar than matic avant. It e M	0	17. Father's Name (First, Middle, JERRY BRANCH	Last)			18. Mother	s Name (First, Midd			
Important: If Itam 27 is marked o any injury or other traumatic ave once.		19a. Informant's Name/Relations					or Rural Route Num			•
am 27 ther ti		MARGARET BRANCH 20a. Method of Disposition	(MOTHER)	20b. Place of Disp		AVE.	BALTIMORE Date	-7	YLAND 2. ation - City or T	
vsician ledical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each li	the death Do not er	412 E. PR	ESTON	STREET BA	LTIMOF	GGS FUNI RE, MAR	ERAL HOME YLAND 2121 Approximate Interval Between Onset and Death
hysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last	с.	a consequence of): a consequence of):						
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y the a	<u>-</u>	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	underlying cause giv	ren in Part I.		tobacco use		he cause of death? bably 4 Unknown
signed by the d be detached	ξ					-			prior to co	opsy findings available
has been signed by the je 2 should be detached	Completed by						per	opsy formed? 2000	death? 1 Ø Yes	2 □ No
certificate has been signed by the rector, page 2 should be detached	Be Completed by	25. Was case referred to medical examiner?	Hospital:	and a MEDIO Markin	ot all post Oth		aut per s f Death (Check only	formed? 2XXNo one)		
or: Affer this certificate has been signed by the he funeral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner? 127 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investig 2 Accident \$ Could r	28a. Date of Injury Fourth 0 a 3-1-05	28b. Time (Found 3:30	of 28c. Injur Wor 1 □	ler: 4 □ Nurs	aut	opsy formed? 2000 vone) sidence 6 [e how injury of	☐Other (Specificoccurred	(y) unk
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 20b per fh 9841 3-9-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 4:52 PM Norman BROWN tebrum 27 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death medical Center Baltimore NA If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** -76-8989 Months 1**∑**M 2□F Director Yrs. and Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits other traumatic event, the Medical Exeminer must be putified at 1 Xes 2 No Directo Maryland mor 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with ŏ or Items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by Specify: 3 Widowed 4 Divorced Blac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sa blea 0 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SCOWIN 19a. Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, VIa. 212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatore of Funeral Service Licensee Funeral He Home W. North Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Immunode Gerenza disease or condition resulting in death) Acquired /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ğ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an page 2 certificate has autopsy performed? 2 100 Division of Vital 1 Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m February 27 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Paul 21201 Chm Stina 5+ Baltimore land lomer 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

			1 - For State Registrar	State of Mary	/land / Depa		dealth and	Mental Hyg	9	0.7856
		**	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea		3. Time of Death
	Physic		Vernon Ray Bail	ev				March	4, 2005	1:00 A M
	/Medi Exami		4a. Facility Name (If not institution, given			4b. City, Town, o	or Location of Deat		4c. County of Deat	
#J:	_ Adiiiii	ię.	629 Gayle Drive				um Height		Anne Aru	
	Funeral	12.	4		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth (Month, Day,		hplace (State or Foreign ountry)
	Director		235-38-7643	1 ∑ M 2□F	78 Yrs.	Months Days	Hours Min.	JAN 8, 1		st Virginia
	D.		Usual Residence of Decedent	, , , , , , , , , , , , , , , , , , , ,					<i>321</i> , NC	oc virginia
	show	h-a	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits
	Ba-f	cto	MD Anne Ar	rundel 1	Linthicum	n Heights				1 ☐ Yes 2√ No
	or 2	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28a-f show he Muzical Examiner and be notified at	Funeral Director	629 Gayle Drive	2		21090			USA	-
	sems sems	Ine	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	or l		1 Never Married 21 Married	1√2 Yes 2 □ No If Yes, Give	Army	1 ☐ Yes 2 ☑ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: wh	
ö	uraľ uraľ	Completed by	3 Widowed 4 Divorced	Year or Dates: 194	45-46				opecny. WII.	106
21215-0036	"nat	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of wor	rking	16b. Kind of Business/	Industry
12	withir ane. Ithan	F	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	,			
22	filed with Hygiene. Ather than		12 17. Father's Name (First, Middle, Last	<u></u>	Regi	onal Eng		ne (First, Middle, M	B & O Ra	ilroad
Maryland	ntal ntal	Be	Edward Walter Ba							
2	and Mental and Mental Is markad c	2	19a. Informant's Name/Relationship		10h Maille	na Address (Cause)		Chamber		
Ma	d 2 s th an 7 Is traus		Mary Jo Bailey -	** * *				nicum Hei	City or Town, State, Z	
αĵ	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "naturat", or items 23s or 28a-f show or other traumatic event. The Marzeal Examiner must be notified at		20a. Method of Disposition					_	20c. Location - City or	21090
õ	to troit of or or or or or or or or or or or or or		1 XX Burial 2 □ Cremation 3 □		20b. Place of Dispo					
Baltimore,	it. Pi		* 4 □ Donation 5 □ Other (Speci		Meadowrid			//2005	Elkridge,	MD
Ba	permit. Pages Department of h Important: If ite any injury or of		21. Signature of Funeral Service Lio	lidoman	Ga	Name and Addre LY L. Kai 50 Washii	ufman Fur	eral Hom	e@Meadowr:	idge MP, Inc. 21075
	/Medical Examiner provided the	cal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	onsequence of):	Ceme				Interval Between Crise and Death
. Box 68	that the death certific ed by the attending pl detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions of	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3 = of death 5	Ectopic pregnancy Other (specify)		23e. Did tob	23d. Date of deline Month	Day Year
ords,	w requires been sign should be	ted by						1 ☐ Ye	s 2 □ 10 3 □ Pro	obably 4 Unknown
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Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	о П = D (0 · · · ·	t 30 DOA Oth		th (Check only one		-1
	ling I. After fune	ertification; To	27. Manner of Death 1 Accident	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injun	/ at	ome 5 ☐ Resider 28d. Describe ho	nce 6 other (Spec. w injury occurred	iv)Nesp1a
=		Certific	3 Suicide 6 Could not b	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or within 24 hours afte Lo the Funeral Dir completely filled in	edical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the I	Me	29b. Signature and title of certifier	1/1		29c. License	number .	29	d. Date signed (Month,	Day, Year)
	. 11	1/	Mushid	(la Down	Ille VI	0-	2790	7-	Mar 4	1) 1115
9	ny)	-	30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	119	-	100	12000
1	VA		Edurad	Some	ر ا زیر	140	. 275	6 NOPIN	St. 1501	t. MDZno
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 0 9 26	3. Registrar's S	Signature	de		, Creius		, , , , , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month
) 3 Dav Year **Physician** Jeanne Elizabeth Borsella 5,35 am 05 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Franklin Square
5. Social Security Number 6. S Hospital Center Rosedule 14 more 8. Date of Birth (Month, Day, Year) 11/23/1928 If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours 76 1 ☐ M 2 🙀 F 217-26-1352 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State "natural", or Items 23a or 28a-f show Parkville Baltimore MD 1 TYes 2 X No Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 9257 Bellbeck Rd. 21234 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Inc. 12 Final Inspector n/a 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Green Thomas Tobin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1308 Stevens Ave., Arbutus, MD 21227 Richard Borsella/son Department of Health Important: If item 27 20b. Place of Disposition (Name of cematery, crematory or other place)
MeadOwridge
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/8/2005 Elkridge, MD 4 □Donation 5 Other (Specify) any injury 22. Name and Address of Facility Gary L. KAufman Funeral Home at Meadowridge Memorial Park 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Fun ral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arrhythm 3 hours Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Fespiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit certificate be executed 10 years moh a

Due to or as consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atherosclerstic heart diseuse Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2∏ No 2 DNO 1 Yes Hospital or Attending Physician: 24 hours after death, Funeral Director: After this certifice 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 1 Yes 2 No 2 ☐ COutpatient 3 ☐ DOA 0 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature of d title of certifier 2 13-05-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheridan 9000 Fran Klin Square Drive Baltimore, Md. 21237 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAR 0 9 2005

Borsella, Jeanne

				1 - For Amend Item 29d per Dr. G841,030	artment of Health and N 99.05dhb Infilicate of Death	Mental Hygie	ne 0 0 5	07858
				1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
		Physici /Medi		Albert Benton Cooper		February	25, 2005	9:45 p M
		Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	ath
				Oak Crest Care Center	Parkville		Baltin	
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 8, 15	9. Bi 925 Mar	rthplace (State or Foreign Country) Cyland
		and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
		ne Maryi 8e-f sho zijijed s	Director	Maryland Baltimore Parkvill				1 ☐ Yes 2 No
		vith th	Dire	10e. Street and Number	10f. Zip Code		Citizen of What C	country?
		s 23g	erai	8800 Walther Blvd. #3221 Westwood Ct			JSA	
. ^ .	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28e-f show with jujury or other traumatic event, the Mcdical Examinar must be notified at 2006.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
5h:6	9	2 hot	ted	15. Decedent's Education 16a. Dece	edent's Usual Occupation	. 16b	o. Kind of Business	
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	<u>\</u>	i Men Marke narke	To	John W. Cooper	Charlot		Barnsley	
	Baltimore, Maryland 21215-0036	12 sh hand 7 Is n traun			ing Address (Street and Number or Rura			
N	e,	1 and Healt am 2		20a. Method of Disposition 20b. Place of Dispo	Walther Blvd. #32		DIE, MAI Location - City o	
0	no	ages nt of t: if it		1 Burial 2 Cremation 3 Removal from State	matory or other place) Service Corp. 2/28/			
$\overline{\Lambda I}$	ij	artme artme ortan injury			2. Name and Address of Facility	700	owson, Ma	ork Road
32/05	Ba	permi Depa Impo eny ir		Cal de lang	luck Towson Funeral			
4				23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
6-		Physician		Immediate Cause (Final disease or condition resulting in death) a. Ischemic	Bowel			Onset and Death
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ON 3	2		<u>~</u>	Sequentially list conditions, and any, leading to immediate b. Small but for as a consequence of).	wel obstruc	tion		
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_0	ŏ	w requires that the death certific been signed by the attending pi should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□	□Ectopic pregnancy		23d. Date of de	livery
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-		requires that the een signed by th nould be detache	b	Part II. Other significant conditions contributing to death but not resulting in the u				o the cause of death?
L	ecords,	requi	ted	Advanced Alzheimer's	Disease	1 L Yes	2 L25(No 3 P	robably 4 Unknown
9)	ec	alaw nasb e 2 st	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
9	H	: The cate his page	Cor			performed		2 No
9	Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	l au	Check onl one		
()	of	Phys	. To	1 Inpatient 2 En/Outpatier	nt 3 DOA 4 Nursing Ho	me 5 🗌 Residence 28d. Describe how in		city)
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2	Dİ	al or s after il Dira	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St.	ate)	
43		To the Hospital or Attanding Physician: The lav within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deatter and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
+		To th within Fo th compl	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Mont	h, Day, Year)
		Y		a monico	058646	Feb	ruary 28	.2005
	1	0		30. Name and address of person who completed cause of death (Item 23a) (Type,				,
	_	\ \ \			arkuillo, MD	21231	٦	
		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
		Registr	ar	MAR 0 9 2005	U			

DHMH 17 Rev 1/2001

			State of Maryland / Departm 1- State Registrar AMEND ITEM #1 PER PHY G841 3965/16			pe) () 5	07859
	Physici	an	1. Decedent's Name (First, Middle, Last) MARVANETTE C		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Correct MINKUM NELLS	City, Town, or Location of Death	Month O3	O OS 4c. County of Deat	11:15p. [™]
	Examir	ier		altimore		4c. County of Deal	n
I	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year If Under 24 Hrs. https://doi.org/10.1016/	8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign buntry) SC
	yland low		10a. State 10b. County 10c. City, Town or Location	ı			10d. Inside City Limits
	e-fsh	ctor	MD NA Baltimore				1X Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number 10	f. Zip Code	10g.	Citizen of What Co	untry?
	s 23e	erai	3305 Powhatan Ave	21216	-if . V N -	U.S.A.	
10	fter d	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes. 1 □ Yes.	Decedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto I	Rican, etc.)	14. Race - Ame Black, White	e, etc.
5-0036	72 hours after death with the Maryland netural', or Itams 23a or 28e-f show dical Examiner fount be notified at	by	3 ☐ Widowed 4 ☐ Divorced	es 2.∭No <i>Specify:</i>		Specify: I	Black
15-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind to the kind	Usual Occupation of work done during most of workir of use retired)	ng 16b	. Kind of Business/	Industry
2121	within iene.	omp	Elementary/Secondary (0-12) College (1-40r 5+)	Examiner		rial Sec	curity Adm
	be filed tal Hygi d other event, t	BeC	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		culity Adm
ylar	tould be a Mental and arkad o		Harold R. Heyward	Leola M	umford		
Maryland	12 sho h and h smd 7 is mu			dress (Street and Number or Rura		ty or Town, State, Z	Zip Code)
	of Health item 27		Leroy Cooper-Husband 3305 Ec 20a. Method of Disposition 20b. Place of Disposition	Owhatan Ave, (Name of ror other place)	Balto, 1	Id 212] Location - City or	Town, State
Ö	Pages ent of nt: If it		2525			-75 -0000011	
Baltimore,	permit. Pag Department Important: I any injury o		KING MEMOR	rial Park 3/7 ne and Address of Facility ch_F/H_West	/05 Rai	ndallsto	own, Md
m	Depa Impo any ir		Wille Edmond 4300	Nabash Ave,	Baltimo	ore, Md	21215
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Metastic BVA	east (ancer	·		Onset and Death
	/Medical Examiner		Duy (or as a consequence of):	Cancer			6.6.5
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).	in the second			
V	and I-transit	Examiner	Sequentially list conditions, if ariy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	in Ca			
90,	ate be executed hysician and he burial-transit		Pue to (or as a consequence of):	re Pa.			
8760	icate b physic s the b	dical	d. Mexastre acri	a cac			
). Box 6	aath certif attending for use as	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Othe	oic pregnancy or (specify)		23d. Date of deli Month	very Day Year
P.0	that the di ed by the detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I	23e. Did tobaco	o use contribute to	the cause of death?
Records,	luires tha n signed ild be det	d by	Steroid Induced Diab		1 ☐ Yes		obably 4 □Unknown
CO	aw requir s been si 2 should	Completed			24a. Was an	24b. Were au	topsy findings available
Re	nding Physician: The lav th.: After this certificate has gruneral director, page 2	mo			autopsy performed	prior to death? No 1 ☐ Yes	ompletion of cause of 2 ☐ No
Vital	cian: ertifica actor,	Be C	25. Was case referred to medical examiner?	26. Place of Death	Check onl one	Heme	Hospice
of \	Physic this or al dire	은	1 ☐ Yes 2 No Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐		ne 5 Residence	6 □Other (Spec	rify)
no	ding I h. After funer	tion	27. Manner of Death Natural 5 ☐ Pending (Month, Day Year) Accident investigation M	28c. Injury at 2 Work? 1 ☐ Yes 2 ☐ No	8d. Describe how in	njury occurred	
Division	Attendii r death. actor: A sy the fu	fica	3 Suicide 6 Could not be		8f. Location (Street		ral Route Number,
ā	tal or A s after al Dirac ed in by	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	ate)	
	To the Hospital or Attanuwithin 24 hours after deatl To the Funeral Diractor: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occu 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, a ation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To To Com	2	29b. Signature and title of certifier Solve of DIAD - Physician	29c. License number	29d. I	Date signed (Month	
7						3-03	0-02.
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCID SMENCE ALD EVANUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature	in Sp. Drive,	Soute 3	321 B	4CTO NID
	Sta Registr		1 9 2005 Level A Starke		<u> </u>		

		_ rot	epartment of Health and Certificate of Death	Mental Hygier	CHR5 11 / R511			
Physi /Med Exam	dical	1. Decedent's Name (First, Middle, Last) 2 2 2 2 2 4 4 4 Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dear	03 05	Day Year 3. Time of Death 5:04a M			
Funera		Franklin Square Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Rosedale		Baltimore 9. Birthplace (State or Foreign			
Directo		213-03-7204 1□ M 2 ★F 88 Yrs Usual Residence of Decedent		8. Date of Birth (Month, Day, Yea Oct. 26,				
e Marylar 8a-f show tiffled at	ctor	10a. State 10b. County 10c. City, Town of Baltimore Es	SSEX		10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
ath with th 23a or 26 unt being	Funeral Director	10e. Street and Number 618 Maryland Ave.	10f. Zip Code 21 221		Citizen of What Country?			
portition of sylvairy states and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I important: If time 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at	Ď.	3X Widowed 4 □ Divorced tf Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (5 tf Yes, specify Cuban, Mexican, Puer 1 Yes 2 \(\overline{\textbf{Z}}\)No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
d within 72 h giene. ar than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HO	ecedent's Usual Occupation live kind of work done during most of wo fe. DO NOT use retired) DMEMAKET	orking	. Kind of Business/Industry			
y idila nould be file d Mental Hy narkad other natic event,	To Be (17. Father's Name (First, Middle, Last) unknown	unkno					
mand 2 sh lealth and m 27 Is n her traun	1	George Creager /son 6	lailing Address (Street and Number or R 18 MAryland Ave	. Baltimo	ore MD 21221			
mit. Pages 1 partment of H portant: If ite		cemetery,	isposition (Name of crematory or other place) illCemetery 3/8		Location - City or Town, State			
permit. Depart Import	9000 9000	21. Signature of Funeral Service Licensee	22. Name and Address of Facility C	_	neralHomeofEssex			
Physicia		shock, or heart failure. List on an cause on each line. Immediate Cause (Final disease or condition	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between			
wedica cate be executed by sician and the buriat-transit	_	Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						
The law requires that the death certific are has been signed by the attending page 2 should be detached for use as it	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mop ws? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year			
requires that een signed b	by P	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
The law rection to has bee age 2 sho	Completed	Channers de Milies		24a. Was an autopsy performed				
VICAL DESIGNATION OF THE SAN CONTINUES OF THE SAN C	o Be C	25. Was case referred to medical examiner?	Othor	ath (Check only one)				
Untained To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certilicate has completely filled in by the funeral director, page 2	⊢		e of 28c. Injury at	Home 5 Residence 28d. Describe how in				
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
he Hosp in 24 hou ha Fune pletely fi	edical		eath occurred at the time, date and place r investigation, in my opinion, death occurred	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)			
Tot With Tot	2	29b. Signature and title of confider Aucel persons						
5		30. Name and address of person who completed cause of death (Item 23a) (Tyler Charles of	pe. Print)		Beruse Mb			
Regis	State strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 9 2005	to face.					

		1 - Stete Unpend Item Registrer 1. Decedent's Name (First, Middle, La		0042C8	rtificate of	Death	2. Date of De		0 1/	O D I
Physicia /Medic		Lisa Ar	,	lisle			Month FEB.	2 ^{pay} , 200)Year 09	ime of Death
Examin		4a. Facility Name (If not institution, given 3766 PATUXENT C.			4b. City, Town, o	or Location of De		4c. County		
Funeral Director		213-76-0146	ex	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		h y, Year) , 1965	9. Birthplace (S Country) Washing	State or Foreign
inied within 72 hours after death with the Maryland Hygiene Hygiene 1.4 Hygiene 1.8 How ther then "neturel", or items 23a or 28a-f show ent, the Medical Examinal must be notified at		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					ide City Limits
a-f sh	tor	MD Anne An	unde1	Davidso	nville]Yes 2∏xNo
or 28	Jire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
23a	rail	3766 Patuxent Cr			210			USA		
Important: If item 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other traumetic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Nøver Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🏿 No		(Specify Yes or No- erto Rican, etc.)		- American Indi , White, etc. White	an,
Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w d)	rorking	16b, Kind of Bus	iness/Industry	
nt, th	Co	12 17. Father's Name (First, Middle, Last,		Admir	istrativ			State D		
C eve	To Be	Jay L. Welch					am <i>e (First, Middl</i> e, Ann Ke11 [.])	
umeti	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street		Rural Route Numbe	<i></i>	itate. Zin Codel	
er tra		Jay L. Welch (Fa	ther)				Harwood			
or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □	Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location - C	ity or Town, Sta	ate
lury		* 4 ☐ Donation 5 ☐ Other (Specif) La	kemont	Mem. Gdn	s 3-5-	-2005	Davidson	ville,	MD
Impor eny in once.	10 11	21. Signature of Funeral Service ricer	S00	22	Name and Addre Hardesty 12 Ridge	Funeral	L Home, P	.A. olis. MD	21401	
attending physician and local sea as the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	quence of):	ated wit	h myocar	dial fib	cosis		and Death
	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3□	Ectopic pregnancy Oth <i>er (specify)</i>	,		23d. Date Mont	,	Year
		Part II. Other significant conditions o	ontributing to death but not res	sulting in the ur	derlying cause giv	en in Part I.		bacco use contrib es 2 □ No 3	ute to the cause	of death?
3 -	e Completed	25. Was case referred to medical						ned? de 2 □ No 1	ere autopsy find or to completion ath? Yes 2 No	of cause of
w E	0 0	examiner? 1X Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Oth		eath <i>(Check only on</i> Home 5 🗆 R <i>e</i> side		(Cassita) AT	SCENE
After th funeral	ation: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at ⟨? Yes 2 □ No		ow injury occurred		SCENE
filled in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - At h building, etc. (Speci	omø, farm, stre y)	et, factory, office		28f. Location (St. City or Town	reet and Number n, State)	or Rural Route	Number,
he Fur pletely	edicai	29a. Certifier (Check only one) 1☐ Certifying Ph (Check only one)	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wiedge, death ition and/or inv	occurred at the tin estigation, in my of	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and mannate and place, and	er as stated. d due to the cau	ise(s)
to con		29b. Signature and title of certifier headen M,	In mo		29c. License OCME		2	9d. Date signed (FEB. 2	Month, Day, Ye. 8, 2005	ar)
Car		30. Name and address of person who o	completed course of death (Iter	n 23a) (Type, F	Print) Pe	nn Stre	et Baltim	ore, Mar	yland 2	1201
	e	31. Date filed (Month) (Par) Yar)	100 32 March Signs	dire /						

			. For	State of Maryland /	Depa	rtment of h	lealth a	nd Mental H	lygiene	A	
		_	State Registrar		Cer	tificate of	Death	10000	Reg. No	005	07852
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) LINDA 5,	DUNCAR)			2. Date of Month		2005	3. Time of Death 0310 M
	Examin		4a. Facility Name (If not institution, give s	12/ 1/20		4b. City, Town, o	Bu	Death	4c. (County of Death	
	Funeral Director		5 Social Security Number 6. Sex		<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of (Month, Aug.	Birth Day, Year)	9. Birthy	olace (State or Foreign ntry) Maryland
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
	the Mar 28a-f sh	rector	Maryland Anne Aru	nde1	Seve	rna Park			10g. Citiz	en of What Cou	1 □ Yes 2 ₩No
	23e or	ai Di	262 Tolstoy Lane			211	46		Un:	ited Sta	ites
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. The marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of the fixes, specify Cub 1 ☐ Yes 2X No		in? (Specify Yes or Puerto Rican, etc.)		4. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0036	natural	ieted t	15. Decedent's Edu (Specify only highest grade	cation 16 e completed)	6a. Deced (Give	ient's Usual Occu kind of work done DO NOT use retire	pation during most	of working	16b. Kir	nd of Business/In	
212	ed withii ygiene. her than it, the M	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		fice Acc	ountan			vis & He	emphill
and	d be fil antal H ced otl	o Be	17. Father's Name (First, Middle, Last) George E1m	er Litchfie	e1d			izabeth		len	Turner
ary	should Ind Men	To	19a. Informant's Name/Relationship (Ty			ng Address (Street	and Number	r or Rural Route Nu			
Ž,	s 1 and 2 of Health a item 27 li other tra		Francis E. Duncan/			olstoy L		Severna Pa		aryland	
Jore	ages 1 nt of H : If item or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 R	temoval from State		sition (Name of matory or other pla	4				
altin	permit. Pages 1 Department of H Important: If ite any Injury or ot once.	1	4 □ Donation 5 □ Other (Specify) 21. Signifure of Funeral Service License		DC	1 Cremat Name and Addr naldson	ss of Facility Funera	1 Home &	Crema	nton, Ma tory, P	.A.
<u> </u>	20729		23a. Part. Enter the disease, or compli	mao M00957	14	11 Annar	olis 1	Road Ode	nton,	Marylan	d 21113 Approximate Interval Between
	Pnysician /Medical Examiner	- do	shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequent	Ce of): 1		-	suffic		/	Onset and Death
68760,	cate be executed oblysician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence)	ce of):						
O. Box	The law requires that the death certificate tee has been signed by the attending phy agge 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown	23c, If yes, outcome of pregnancy 1 Live birth 2 Fetal de. 4 Pregnant at time of death 9 Unknown	ath 3	☐Ectopic pregnanc ☐ Other (specify) _	y		_	3d. Date of deliv Month	ery Day Year
Δ.	uires that n signed b	ρ	Part II. Other significant conditions con	ntributing to death but not resultin	ng in the u	nderlying cause g	ven in Part I.	ì	id tobacco u	0	the cause of death? bably 4 Unknown
Vital Records,		Completed					00 Bl	1 🗆 Ye	utopsy erformed? es 2 17 No	24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available ompletion of cause of 2 No
	Physicien: this certific ral director,	o Be	25. Was case referred to medicat examiner? 1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 VER	/Outpatier	nt 3 DOA Ot	han	of Death (Check or rsing Home 5 - F		G □Other (Speci	fy)
on of	ding Phy h. After this funeral c	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	The second secon	Bb. Time o Injury	f 28c. Inju	iry at ork?] Yes 2 □ 1		be how injur	y occurred	
Divísion	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	a, farm, sti	reet, factory, office			n (Street and Town, State)		al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	vsicien: To the best of my knowle iner: On the basis of examination and manner stated.	ndge, deat n and/or in	h occurred at the tivestigation, in my	ime, date and opinion, deat	d place, and due to th occurred at the tir	the cause(s) ne, date and	and manner as s place, and due t	stated. to the cause(s)
)	VA .	Me	29b. Signature and title of certifier	Depu	144 n D	00	se number	54	29d. Date	e signed (Month,	Day, Year)
	1,8		30. Name and address of person who co	completed cause of death (Item 23	3a) (Type,	Print)		a 21	035		
	St: Regist	ate	31. Date filed (Month, Day, Year)	36. Registrar's Signature		ale					

DHMH 17 Rev 1/2001

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State of Maryland / Department of H	lealth and Mental Hygiene 🕕	1

			For State Registrar		State of Ma	aryland				ealth a D <i>eath</i>	nd Me	ental Hy)	078	163
			Decedent's Name (First, Middle, Las	st)						2	. Date of D	Rag. No eath	·		3. Time o	of Death
	Physici		Frances		Ann		Daly					Month March	2 2	^y 2005	Year	4:30	ам
	/Medi Examir		4a. Facility Name (If n	ot institution, giv			<u> </u>	4b. City,	Town, or	Location of		riar Cir		. County o		7.50	a_
			707 Hera:	ld Harbo	r Road			С	rowns	sville	2			Anne	Arun	da1	
	Funeral	_	5. Social Security Num	nber 6. S	ex 7. Ag	e (In yrs. la	ast birthday)	If Unde	r 1 Year	If Under 2		Date of Bi			9. Birthp	lace (State	or Foreign
	Director	١.	578-48-4	102	□ M 2 🛣 F	68	Yrs.	Months	Days	Hours	MIN.	Sept.	26 .	1936	Couin Ten	nesse	e
	pu ▶		Usual Residence of D			10a City	, Town or Lo										
	anyla shov	<u>-</u>	Toa. State	0b. County		Tuc. City	, rown or Lo	cation							11	0d. Inside C	-
	Ba-f	ecto	MD	Anne Ar	undel	Cr	ownsvi										NO XIX
	with th	D I	10e. Street and Numb					10f. Zip	Code				10g. Ci	tizen of Wi	nat Coun	try?	
	s 23	sra	707 Heral	ld Harbo		5		** - 5	210					USA			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, I're M. dic. Exa. vill ptr.; ust be ricultived and once.	Funeral Director	11. Marital Status 1 ☐ Never Married	207 Marriad	12. Was Decedent I Armed Forces? 1 □ Yes 2 ☑ N		5. 13.1	f Yes, spe	dent of His cify Cubar	spanic Orig n, Mexican,	Puerto Ri	fy Yes or No can, etc.)	0-	14. Race Black	- Americ , White, e		
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ar	sho and l	ľ	19a. Informant's Nam	e/Relationship (Type, Print)		19b. Mailir	g Address	(Street a	nd Number	or Rural F	Route Numb	er, City	or Town, S	tate, Zip	Code)	77
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	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Diractor: Atter this certificate h completely filled in by the tuneral director, page	Medical	(Check only 2[one)	Medical Exam	niner: On the basis of and manner sta	examination	on and/or inv	estigation	in my opi	nion, death	occurred	at the time,	date and	place, and	d due to	the cause(s)
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il	7/1 -		30. Name and address	of person who	completed cause of de	ath (Item	23a) (Type 1	Print)					0100		7_		
10	/ _		STANLEY	WATK	-	/ho	3135		7/3	Ris	B	NNA	mode	15 ~	n ?	140	i
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	Registr		design	MAR 09	2005	.60 a	# 1	A	5								

State of Maryland / Department of Health and Mental Hygiene For Stata Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 12:51 P M Neil Dobbertean Winston 2005 March 1 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 228 Oakwood Road Dundalk Baltimore Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ F Yrs. 055-26-5226 72 Director Oct. 18,1932 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 228 Oakwood Road 21222 Items 23e United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Afmed Forces: 1 [X]Yes 2 □ No If Yes, Give Year or Dates: Korean filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 Yes 2 No Specify: Specify: ģ 3 XWidowed 4 ☐ Divorced 'naturel', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Engineer Chemical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental He tant: if item 27 is marked oth jury or other traumatic even Be Leonard Dobbertean Lyla Small 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Stepdaughter Linda Rider 2611 Gray Manor Terrace Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State permit. Page Department Important: if eny injury or Oak Lawn Cemetery 4 Donation 5 Other (Specify) 3/4/2005 Baltimore, Maryland Funeral Service License 21. Signature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for as a consequence of: Examiner The law requires that the death certificate be executed 200 and Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 210 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ Ho Jo 1 Inpatient 2 ER/Outpatient 3 DOA 5 Sesidence 6 Other (Specify) this nours after death.

nerel Director: After this

filled in by the funeral d 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature at nd title of certifie 0) LLC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLSEN WD 0+1 0. 3360 28 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley G. 3MC 6701 N. Charles St. Balto Md 2, 2005	1	10		W.A. Riley		a) (Type, Pri	N-Cha	ileo St.	Balto	. md 2	20%
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				State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Death Certificate of Death Reg. No. 0 7 8 6
		Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) KENNETH L. EDWARDS 4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice 2. Date of Death Month Day Year 2005 2:40P M 4b. City, Town, or Location of Death Baltimore
		Funeral Director		5. Social Security Number 6. Sex 1 1 M 2 F 58 7. Age (In yrs. last birthday) 1 M 2 F 58 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 4. Age (In yrs. last birthday) 1 Months Days Hours Min. 5. Social Security Number 1 Months Days Hours Min. 1 Months Days Hours Min. 1 Months Days Hours Min. 1 Months Days Hours Min. 1 Months Days Hours Min. 1 Maryland
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		urs after deeth with the Maryla al', or items 23a or 28e-f shov Examinet must be notified at	by Funeral Director	44 Flintville Road 21160 USA 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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3/5	Maryland	2 should be f and Mental I is marked of aumatic eve	To Be	Clinton Edwards Hettie Ann Monk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7		Heelth a tem 27 is other tra		Pauline Forbes/Daughter 492 Big Mount Road, Thomasville, PA 17364 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Date 20c. Location - City or Town, State 20c. Locati
andra	Baltimore,	permit. Pages Depertment of Important: If i any injury or once.		Darlington Cemetery 3/7/2005 Darlington, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hancins Funeral Home, Inc., 600 Main St., Delta, PA 17314
9		Physician		23a. Part. Enter the disease, or complication that caused the deat of not enter the mode of dying, such as cardiac or respiratory arrest, such as cardiac or respiratory arrest, or hear failure. Lift only one close on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Approximate Interval Between Onset and Death Onset
105	68760, <	Medical Examiner bhysician and to the burial-transit	edical Examiner	Immediate Cause (Final dis as or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): d.
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dwan	-	sician: The law r certificate has be rector, page 2 sh	Completed	24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
SK E	Division of Vit	ing Phys n. After this funeral di	Certification: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28b. Time of Injury Work? M 1 Yes 2 No
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A A		To the Ho within 24 h To the Ful completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	22	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILLAR G HAYES, MY; 827 LINDEN AVE - BALTO 14d 21201 31. Date filed (Month Day Year) 22 Persistrate Signature
		Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2005 33 Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					State	JI IVIAI YIA		ertificate of	nealth and i Death		Reg. No. 2	105	07077
			Decedent's Nam	e (First, Midd	le, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physiciar /Medica		Elizab	eth V	irginia	Ferre	eri			03/02	/2005	Teal	8:20 PM
	Examine	4 -			n, give street and nu				4b. City, Town, or I	ocation of Deat	4c. County	of Deeth	
		30	Fairfi	eld N	ursing 1	Home			Crownsv	ille	Anne	Aru	ndel
	Funeral	5.	Social Security N		6. Sex		s. last birthda	y) If Under 1 Yea Months Days	r If Undar 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th (v. Year)	9. Birthp	olace (State or Foreign
	Director		219-22- suel Residence o		1 ☐ M 2 📜 F	94	4 Yrs.	Monto Day.	Tiodro Willin	07/15		000,	MD
	show		Da. State	10b. County			City, Town or					1	0d. Insida City Limits 1 ☐ Yes 2 ☐ No
	Ne M	Š	MD		Arundel		Baltin				10- 00:	1411 - 1 0	
	Aith t	5 "	e. Street and Nu					10f. Zip Code			10g. Citizan of		rury r
	23 a	<u> </u>	212 Hil . Marital Status	lcres	t Avenu	edant Ever in	IIC 1	21225		pacifu Vac or No	U.S.	A . ce - Amaric	ean Indian
020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show out, the Medical Examiner must be notified at the Commission of t	2	1 □ Never Marr 3 ☑ Widowed	_	ried Armed F	orces? 2 🔊 No ive	0,3.	If Yes, specify Cu 1 ☐ Yes 2 🕱 No	Hispanic Origin? (S ban, Maxican, Puart Specify:	o Rican, etc.)	Bla Specif	ck, Whita,	
5-0	22 ho	3	/Sno	15. Deceder	nt's Education est grade completed	1	16a. Dec	cedent's Usual Occu	upation	kina	16b. Kind of B	usiness/înc	dustry
21215-0020	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturn any injury or other traumatic event, the Medical is DRG.		Elementary/Seco		1	(1-4or 5+)			e during most of wor ed)	King	Ozzn	IIawa	
	Hygie Hygie ther I		10 '. Father's Name	(First Middle	l ast)		Н	omemaker	18. Mother's Nan	ne (First, Middle	Own .		
Maryland	2 should be fill and Mental H is marked off reumatic ever	ŏ	Charles	a)					Addie	Eliza	hoth I	owie	
Z	M Me				ship (Type, Print)	-	19b. Ma	illing Addrass (Stree	et and Number or Ru				(Code)
Z	d 2 s Ith an 17 is trau		,		Daughte:	r			ad, Pas				,
ē,	Health tem 27 i		a. Method of Dis	position		20b	Place of Dis	position (Name of		Data	20c. Location		wn, State
3altimore,	ages ent of ht: if it y or c		1 Burial 2	☐ Cremation	3 □Removal from			rematory or other playen Men		3/7/5	Glon '	Rurn	ie, MD
=======================================	Department: Pag Department: Important: I any injury o	2	1. Signature of Fu	,		G.							Home, PA
ä	Dep Imp		1:0	2/	Jan-			l69 Rivi	era Dri	ve, Pa	sadena		
		2	3a. Part1. Enter t shock, or hea	he diseese, o	r complications that only one cause on	caused the de each line.	ath. Do not a	intar the mode of dy	ring, such as cardiac	or raspiratory a	rrast,	1	Approximate Intarval Betwaen Onsat and Daath
	Physician /Medical		nmediate Ceuse	(Final	1		//	1	01			1	Orisat and Daatii
0	Examiner	di	isease or conditionsulting in death)	n	a Can	yes her	e K	artit	ulare				Year
				. 3 .		Due to	(or es a cons	equence of):					
1	ficate be executed physician and is the bunal-transit	S	equentially list co	nditions,	b	Due to	(or es a cons	equence of):					
68760,	e exe	i d	equentially list co any, leading to in ause: Enter Unde euse (Disease or at initiated event:	nmediate erlying								į	
876	nat tha death certificate be d by the attending physicia letached for use as tha bur	th re	at initiated events sulting in death)	s Last	· ,	Due to	(or as a cons	aquenca of):					
9 ×	ding pass eas				d							i	
Вох	attending for use			2.01			· ·					1	
o	the a	Pa	rt II. Other signif	icant conditi	ons contributing to d	leath but not re	sulting in the	underlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
, P.O	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit commissed by Dhysician Madinal Examination		Covenes	y a	try du	este				10	Yes 2 No	3 Prot	bably 40 Unknown
Records,	n sign			J	. \						an autopsy	24b. We	ere autopsy findings
00	w rec			2						pend	med?	-001	ailable prior to mpletion of cause death?
Re	The law requir sate has been s page 2 should		.4 3.4		* 0,					101	res 2XNo		Yes 200No
			. Was case refer	red to medica	1				26. Place of Dea				7.00 192-110
>	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 ☐		Hospital:	Inpatiant 2	☐ ER/Outpati	ent 3 DOA O	th av	ome 5□Resi		er (Specifi	v)
10	2 2 7		. Manner of Deat	h	28a. Data	1	28b. Time	of 28c. Inju			now injury occur		
ior	Attending In death. Detor: After by the fune		1 Natural 2 Accident	5 Pendii investi	9	nii, Day 16ai/	Injury		Yes 2□No				
Division	tal or Attending P rs after death. ai Director: After t led in by the funera		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detam	nined 288. Place	e of Injury - At	home, farm,	streat, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	l Route Number,
	Italo Ins aff												
	n 24 hours n 24 hours ne Funei pletaly fil	29	Pa. Certifier (Check only		ng Physician: To the Examiner: On the b	asis of axamir							
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completaly filled in by the ti		one) b. Signature and	title of confin	17.1	ner statad.		29c Licer	ise number		29d. Date signe	d (Month.)	Day, Year)
	F. 3 F. 8	-	1	3/1		1.1			38958		3/2/0	-	
		20	Name and add		who completed cau	N D	om 23e) (Tire				7/3/0		
	ID	30	De la con	A C	W. Can	// //	4/3 A	mar hel	Road -	HIOR	oclanto	14 M1	021/13
	State	31	. Date filed (Mon	th, Day, Year)	32. 1	Registrar's Sig	nature	The forther	12009	4100	- wer it	VIII	
	Registrar		V	NA.	R 0 9 200	Esc.		1 Cornelle	1				

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				State of Ma						-		gible.		
		•	For State Registrar		•	Certifica					eg. No	005	078	368
			Decedent's Name (First, Middle, Last)							Date of Deat Month	th Day	Yeer	3. Time of	Death
	Physicia /Medic		Doff	T. Fleshm	an, Sr.		_		I I	March	7	2005	1:17	P M
	Examin		4a. Facility Name (If not institution, give s		_ 1			Location of D	eath			unty of Death		
			Washington Adventi		al (In yrs. last birth)		er 1 Year	a Park	Hrs. 8	Date of Birth		tgomer	-	or Foreign
	Funeral Director			M 2□F 72		Month			Ain.	Date of Birth (Month, Day, ept 19	, 193	2 Vir	place (State on ntry) ginia	, r orongri
	/land		10a. State 10b. County		10c. City, Town	or Location			·				10d. Inside C	ity Limits
	Man B-f sh	tor	MD Howard		Daytor	1							1 🗌 Yes	2√∑ No
	or 28	Director	10e. Street and Number			10f. 2	Zip Code			1		of What Cou		
	ath w	ra	13517 Orion Drive		- : 110	10.111.0	2103		0./0	. Van an Na		ted St		
	items items	by Funerai	11. Marital Status 1 □ Never Married 2 Married	 Was Decedent E Armed Forces? 1 X Yes 2 No. 		If Yes, sp	pecify Cubar	spanic Origin' n, Mexican, P	uerto Ric	an, etc.)	14.	Black, White,		
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1		1 🗌 Yes	2 ∑ No	Specify:			Sp	pecify: Wh	ite	
ည်	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show tha Modeal Exercinal resultied at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. C	ecedent's Us Give kind of	sual Occupa work done d	ition luring most of	working		16b. Kind	of Business/Ir	ndustry	
2	Athin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5-	-)								7 1	
2	filed w Hygiel other tl	S	12 17. Father's Name (First, Middle, Last)			Lab M	anagei		Name (F	irst, Middle, i		man Ko	dak	
and	Mental I	То Ве	Cecil Fleshman					Nora 3	Jones	5				
Maryland 21215-0036	shoul nd Ma marl umatl	F	19a. Informant's Name/Relationship (Type	оө, Print)	19b. I	Mailing Addre	ss (Street a	nd Number o	r Rural R	oute Number	r, City or T	own, State, Zi	code)	
	1 and 2 Health a tem 27 is		Sally C. Fleshman/	Wife				cive Da	aytor	n, MD	21036			
ore.	es 1 a of He f Item r oth		20a. Method of Disposition	emoval from State	20b. Place of C cemetery,	Disposition (A crematory o	lame of r other place	9)	Date		20c. Loca	tion - City or T	own, State	
Ĕ	Pag Iment tant: I		* 4 □ Donation 5 □ Other (Specify)		St. Lou		_		-12-2			ksvill		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, I'm M. dical Exerciter mast be notified at once.		21. Signature of Funeral Service License	. with	M01044	4112	old co	olumbia	a Pil	ke Ell:	icott	's Fam City,		
П			23a. Part1. Enter the disease, or compli- shock, or heart lailure. List only on	cations that caused to cause on each line	the death. Do no	t enter the m	ode of dying	g, such as car	rdiac or re	espiratory arr	est,		Approximation Interval Bet Onset and	tween
A	Physician		Immediate Cause (Final disease or condition resulting in death)		dial In		on							
	/Medical Examiner		1630 ttill g ill death)		consequence of									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ry Arter		ease_						-	
	outed ansit	Examiner	that initiated events											
oʻ	be executed ician and burial-transil		resulting in death) Last	Due to (or as a	consequence of):								
8760,	ate b	dicai												
x 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 2	3c. If yes, outcome of	of pregnancy						230	d. Date of deliv	erv	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at	2 Fetal death	3 □Ectopic 5 □ Other						Month	,	Year
o.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown										
S, D	es tha igned be del	by P	Part II. Other significant conditions con	tributing to death bu	t not resulting in	the underlyin	g cause give	en in Part I.				contribute to		
Vital Records	w require been sig	ted									es 2 🗆 1		bably 4 🔀	
Sec.	e law has b	Completed								24a. Was a autop: perfor	sy	24b. Were aut prior to co death?	opsy findings ompletion of a	available cause of
alF								00.01	. D 15 //	1 Yes	2 ∑ No		2 No	
Ζ	Physician: this certificantal director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 🔀 Inpatie	nt 2 ER/Out	patient 3	DOA Othe	ac .		5 □ Resid		Other (Spec	ifv)	
of	E E	I	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Ti		28c. Injury Work	/ at		1. Describe h				
ion	ttending death. ctor: Afte	atio	1 Natural 5 ☐ Pending investigation	(World, Day	7 621)	M		Yes 2 □ No						
Division	al or Attending P after death. I Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc		m, street, fac	ory, office		28	. Location (S City or Tow		Number or Rui	ral Route Nun	nber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exemi	sician: To the best oner: On the basis of and manner sta	examination and	death occum or investigat	ed at the timion, in my of	ne, date and p pinion, death	olace, and	d due to the d at the time, d	ause(s) ar	nd manner as lace, and due	stated. to the cause(s)
	o the	Med	29b. Signature and title of certifier	210 11011101 310			29c. License	e number		2	29d. Date	signed (Month	Day, Year)	
	1/1/	2		Mot -			28	883			3	18/05		
	1/1		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type, Print)						100		
_	10			0 Carroll		Takom	a Parl	c, MD 2	20912	2				
	St Regist	ate rar	31. Date filed (Month, Day, Year)	0 9 2005	ar's Signature	in	house							
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #28a PER PHY G849 rtilipade out Dogath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Homer E. Fifer, Jr. 5, A M 7:12 March 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Baltimore City Johns Hopkins Bayview Medical Ctr. N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Yrs Director 63 216-36-0949 May 8, 1941 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TXNo Director Dundalk Maryland
10e. Street and Number Baltimore 10f. Zip Code 10g. Citizen of What Country? 2013 Larkhall Road 21222 United States Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Almed Folces:

1 X Yes 2 No
If Yes, Give
Year or Dates: Korean 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Welding 12 Years Steel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental H Homer E. Fifer, Sr. Mary K. Keister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 Larkhall Road Dundalk, Maryland Health Item 27 I Mrs. Emily E. Fifer / Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₹ <u>=</u> 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any Injury or once. Oak Lawn Cemetery 3/11/2005 5 Other (Specify) Baltimore, Maryland 4 Donation 21. Signature Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Corona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit DI Due to (or as a consequence of): Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, bacc es 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 **X** No 2 □ No 1 Yes 1 Yes of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 XYes 2 □ No funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2DER/Outpatient 3 DOA 70 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. 28d. Describe how injury occurred Injury at Work? After Division Natural Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D56466 March 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD STE 200 BALTIMORE 4924 CAMPBELL SWATI HATAK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH Physician **FASTOVSKY** 2005 6:48 Ρ Ν /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN. 16, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔽 F Yrs. 80 KIEV Director 220-96-0398 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mential Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event, It a Medical Examination with the notified at 1 Ves 2 □ No BALTIMORE Directo N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5715 PARK HEIGHTS AVENUE #306 21215 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify Completed by 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **ACCOUNTING** ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PERETZ. MALINSKY LUBA KAPUSTIN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8805 ORCHARD ROAD - BALTIMORE, MD 21208 LEONID FASTOVSKY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 03/07/2005 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lauro **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Chrowic D-S. e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physiclan Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 XNO 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other. 2 XNO Medicai Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide Fo the Hospital 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Tol D0054746 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 # 206, Baltinure. A-POKOL 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 09

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Marylan		artment of tificate o			2000	07071
			Decedent's Name (First, Middle, Last)	***		imouto o	, Douth	2. Date of De	Reg. No.	3. Time of Death
	Physici		Barbara M. For	eman				March	6. 2005	r
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town	, or Location o		4c. County of De	
	ZAGIIII			Mercy		Bali	timore		n/a	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yes	ar If Under 2		th 9 B	irthplace (State or Foreign
	Director		220-03-2493	M 2 F 8	7 Yrs.	WOTUTS Day	75 Hours	9/21/		eryland
	and *] }	Usuat Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation				10d. Inside City Limits
	farylan show	2					OD E			1 SYes 2 □ No
	or 28a-f	ect	Md n/a			3ALTIMO			10g. Citizen of What (
	th with 23a or	Funeral Director	3412 Mt. Pleasa	nt Ave			1224		USA	Southty?
	ns 2%	era		2. Was Decedent Ever in U.	.S. 13. \	_ 1		in? (Specify Yes or No		nerican Indian,
(0	r iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				in? (Specify Yes or No Puerto Rican, etc.)	Black, Wh	
030	al', o	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I⊡Yes 2∭AN	lo Specify:		Specify: W	Mhite
21215-0036	72 hours after death with the Maryland natural', or Items 23s or 28s-f show Jical Examinational be motified at	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	lent's Usual Occ kind of work dor	cupation	of working	16b. Kind of Busines	
2	thin ie.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use reti	ired)	or working	Social S	Security
7	led w lygier her th		12	0		Clerk			Administ	ration
and D	be fi	Be	17. Father's Name (First, Middle, Last)	1				's Name (First, Middle,	•	
7	1 Mer narke	ဥ	Morris J. Hup		1 40 44 7			a Negenga		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Manial Hygiene. Importance of Health and Manial Hygiene. Importance of Health and Marked other then "natural", or Items 23a or 28a-f show amy injury or other traumatic event, If a Marical Examinational Department and page.		19a. Informant's Name/Relationship (Ty. Mr. Joseph D. H					r or Rural Route Numbe		
o	1 an Heall em 2		20a. Method of Disposition		1 O W 6	sition (Name of	d Cour	t Baltin	nore Md. 20c. Location - City of	
9	ages int of t: If It		1 🔀 Burial 2 □ Cremation 3 □ R	Billoval Ilolli State		sition (Name of natory or other p		/10/05		
Baltimore,	artme ortan injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License						Baltimor	e, Md.
Ba	Depa Impo any iu		Ship List					uneral Ho		rd 01000
	0 100		23a. Part1. Enter the disease, or compli	cations that caused the deat				Ave. Balt		Approximate
	Physician		shock, or heart failure. List only or tmmediate Cause (Final	e cause on each line.	_	en v				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq			, 2000	3 ,		
	Examiner									
		Je	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
	cuted nd ransi	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events							
0	e exe	EX	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dicai								
9 x	leath certific attending p	Mec	IF FEMALE:							,
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	3c. tf yes, outcome of pregna 1 Live birth 2 Feta	I death 3	Ectopic pregnar			23d. Date of d Month	elivery Day Year
o.	the a	by Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of d 9 Unknown	eath 5∟	Other (specify)				Day Tour
a	that the de led by the a detached f	Ph	Part II, Other significant conditions cor	tributing to death but not res	ulting in the ur	deriving cause	civen in Part I	23e. Did to	obacco use contribute	to the cause of death?
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Re	has has	m d						24a. Was autop	ari 240. Were a prior to death?	autopsy findings available completion of cause of
_	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					1 ☐ Yes	2 No 1 Ye	es 22No
Vital	Physician: this certific ral director,	o Be	examiner?	ospital:	ER/Outpatien	t 3 DOA		of Death (Check only o		ecity) HOSPICE
of	Phys arthis araldi	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. in	jury at		now injury occurred	ecity) HOJ Y ICE
ion	Attending r death. sctor: After oy the funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		∛ork? □Yes 2□N	lo		
Division of	Atte	iji	3 Suicide 6 Could not be determined	28e. Place of tnjury - At he	ome, farm, str	eet, factory, offic	же	28f. Location (S	Street and Number or F	Rural Route Number,
ā	s afte	Certification;	4 Normalde	building, etc. (Specify	y)			City or Tow	vn, State)	
	hour hour unera		29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	icien: To the best of my kno	wiedge, death	occurred at the	time, date and	place, and due to the	cause(s) and manner a	as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medicai	one)	er: On the basis of examina and manner stated.	ori and/or in	estigation, in my	y opinion, deat	occurred at the time,	uate and place, and du	ue to the cause(s)
	With To Tool	2	29b. Signature and title of certifier	4.4			ense number	U	29d. Date signed (Mor	
,	0 1/	2	Dr. M	7 -		7	4085	1	3/7/200	ייי
(1/1		30. Name and address of person who co			(1)	1-4.	7	212.3	
			31. Date filed (Month, Day, Year)	1.0		CE Ba	UTIM	ou, Mi	21201	
	Sta Regist			32. Registrar's Signa		door	160			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5 2005 March unknown GEORGE-HARRIS SIGRID K. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE 3438 BELAIR ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days Hours 1 M XXF Vrs 66 1938 PENNSYLVANIA 12 Director 203-28-6401 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28e-f show treumatic event, the Medical Examiner must be rigilitied at 1XIYes 2 □ No MARYLAND N/A BALTIMORE Direct 10g. Citizen of What Country? 10f. Zin Code 10e Street and Number with ö U.S.A. 21213 3438 BELAIR ROAD or Items 23a death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 11 Marital Status Black, White, etc. hours after 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: WHITE à 3 Widowed 4 Divorced Year or Dates "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 72 d 2 should be filed within 7. In and Mental Hygiene. 7 Is marked other than "ne College (1-4or 5+) Elementary/Secondary (0-12) MORTGAGE CREDIT 12th grade CREDIT INVESTIGATOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KATHYRN LINDOR HENRICKSON SR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If item 27 Is r 3438 Belair Rd., Baltimore, Md. 21213 DWIGHT HARRIS/Husband other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition

12∃Burial 2 □ Cremation 3 □ Removal from State ö Depertment of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) WOODLAWN CEMETERY 03-11-05 WOODLAWN, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. permit. 21. Signature of Kaun 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) wals Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as the IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day ō in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) detached o signed by t of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2, No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes certificate To the Hospitel or Attending Physiclen: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: Hospital: 4 Nursing Home 5 Residence 6 □Other (Specify) 3 DOA 1 🗌 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient Certification: To this s after death.
I Director: After this
id in by the funeral d 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Natural Division 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of bertitier 30. Alne and address of person who completed cause of death (Item 23a) (Type, Print) AU 31. Date filed (Month, Day 32. State South Registrar MAR 0 9 2005

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certifica	te of Death	Reg. No.	Alle also come on any one
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	
/Medical Examiner	4a Facility Name (If not institution, give street and number) 21525 Manor View Circle	4b. City, Town, or Lo	ocetion of Deeth 4c.	County of Death Montgomery
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last birthday) Manufacture	er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent			957 Pennsylvania
Maryler f ehow	10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Germantown			10d. Inside City Limits 11☑ Yes 2 ☐ No
O offer death with the Maryle refers 23s or 28s-f elro inner must be notified at Funeral Director	10e. Street and Number 10f. 2	ip Code		zen of What Country?
death w		0876 edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		ted States 14. Race - American Indian,
) 20 Sil. Sil. Sil. Sil. Sil. Sil. Sil. Sil.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:			Black, White, etc. Specify: White
1 21215-0020 led within 72 hours ef lyglene for than "patural; or or the Medical Exami	Elementary/Secondary (0-12) College (1-4or 5+)	ork done during most of work	ring	nd of Business/Industry
Baltimore, Maryland 21216 pemit. Pages 1 and 2 should be filed within 7 Depertment of Health and Mentel Hyglene. Important: if flem 27 is marked other than "neny injury or other treumatic event, tre Med page. To Be Comple	17. Father's Name (First, Middle, Last) Ralph Young	18. Mother's Nam	e (First, Middle, Maiden : beth Lechak	Surname)
Mary		s (Street and Number or Rur		r Town, State, Zip Code) wn, Maryland 20876
Baltimore, Maryland semit. Pages 1 and 2 should be file beperment of Health and Mentel Hy mportant: if item 27 is marked othe ny injury or other treumstic event, ance. To Be C	20a. Method of Disposition Burial 2 Cremation 3 Remayal from State	nme of other place)	eb. 25, Richl	cation - City or Town, State and Township,
Baltimor permit. Pages Depertment of t important: if ite eny injury or of once.	21. Signature of Funeral Service Eldensee 22. Name	nd Address of Facility	enderson Fu	
	23a. Part1. Enter the disease, of complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.			, Pennsylvania
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. CHOLANGIOCAR Due to (or as a consequence of	CINOMA		Interval Between Onset and Death
that the death certificate be executed that the death certificate be executed ed by the attending physician end deteched for use as the buriel-trensit y Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of			
Box eath cert attendin for use	d			
cords, P.O. Boy v requires that the death ce been signed by the attends should be deteched for use leted by Physiclan/	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		use contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☑ Unknown
of Vital Records, Physicien: The law requires th this certificate has been signe ral director, page 2 should be c. TO Be Completed by			24a. Was an autops performed?	sy 24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec sicien: The law certificate hes irector, page 2 a	25. Was case referred to medical		1 🗆 Yes 2 🔰	N∪ 1 Yes 2 No
of Vital Physicien:	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 In	00	th <i>(Check only one)</i> ome 5 Residence 6	□Other (Specify)
Vision C Attending P or death. by the funeral iffication:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Accident Month (Month, Day Year)	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
et a get a	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	29a Certifier (Check only one) Certifying Physician: To the basis of examination and/or investigation and manner stated.	et the time, date and place, n, in my opinion, death occurr	and due to the cauce(s) and at the time, date and	and a mer as stated. place, and due to the cause(s)
To the within To the compl	29b. Signature and title of certifier	c. License number		e signed (Month, Day, Year)
6	30. Name end address of asson who completed cause of death (Item 23a) (Type, Print)	De061083		B. 22, 2005
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		JUU, KOCKVI	11e, MD 20850
Registrar DHMH 16 Rev 6/95	MAR 0 9 2005	و ا		

			1 - For State Registrer	State of Maryland	/ Department of h	Health and Me	ental Hygien	2005	07874
	Physici /Medic		1. Decedent's Name (First, Middle, Las	rff ~		2	2. Date of Death	os Year	3. Time of Death 2. 45pM
	Examin	er	4a, Facility Name (If not institution, give \$53 EVES)	ram Aven	ue Ba	or Location of Death	2	c. County of Death	
	Funeral Director	٥	5. Social Security Number 6. Se 10 11 Usual Residence of Decedent	7. Age (In yrs. las.	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. E	B. Date of Birth (Month, Day, Yea - 2 - 5	9. Birth	place (State or Foreign of try)
	Maryland of show lifed at	tor	10a. State 10b. County	10c. City, 1	Town or Location I timore				10d. Inside City Limits
	hours atter death with the Maryland urel', or items 23a or 28e-f show at Exantiner must be notified at	Funeral Director	10e. Street and Number 853 Evesh	an Avenu	10f. Zip Code	2/2	10g. C	itizen of What Cou	ntry?
96	or Items		11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Speci an, Mexican, Puento Ri Specify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White,	
21215-0036	72 "net	leted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi (Specify only highest grade)	Year or Dates:	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation	16b.	Kind of Business/In	dustry
	be tiled within ital Hygiene. id other than "event, Itie Max	e Completed	Elementary/Secondary (0-12) 17 Father's Name (First, Middle, Last)	Sollege (1-4 or 5+)	Busines	S OUNG 18. Mother's Name (- 10		Municipa
Maryland		To B	Clarence C 19a. Informant's Name/Relationship (7	riFin ype, Print)	19b. Mailing Address (Street	Dons	Ande	rson	(Code)
	Health tem 27 other tr	,	Darleye Gri	FFW (Wyle)	853 EVE te of Disposition (Name of tetery, grematory or other pla	2Sham A	ue, B	ato M	D 21212
Baltimore	permit. Pages Department of Importent: If i eny injury or once		1 Qurial 2 Cremation 3 1 4 Donation 5 Other (Specify, 21. Signature of Funeral Service License	MD	- National (22. Name and Addre	emeters	1/05 BC	1 to .M	ervies
Ä	Dermi Depa Impo eny ii		23a. Part1. Enter the disease, or comp	lications that caused the death.	Do not enter the mode of dying	JORA ng, sych as cardiac or i	respiratory arrest,	alto.	D 21212
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Due to (or as a consequer	Esophage	al Cana	er		Interval Between Onset and Death 20 months
	Examiner	ner	if any, leading to immediate	b. Due to (or as a consequen	V				
) 0,	be executed ician and burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	nce of):				
× 68760	9 s	Medical	IF FEMALE:	d			-		
O. Box	law requires that the death certifica as been signed by the attending ph 2 should be detached tor use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl 9 ☐ Unknown	eath 3 Ectopic pregnancy	у		23d. Date of delive Month	Day Year
ds, P.O.	uires that the de signed by the a Id be detached t	by	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the underlying cause giv	ven in Part I.	23e. Did tobacco	use contribute to the	N/
Vital Records,	0 - 0	Completed					24a. Was an autopsy performed?	24b. Were auto prior to con death?	psy findings available impletion of cause of
Vital		Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3 DOA Oth	26. Place of Death (1 Yes 2 N		2/No
on of	ing Ph Ifter th Ineral	tion: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		Bb. Time of Injury Wor	4 Nursing Home	d. Describe how inju	6 □Other (Specifi ury occurred	//
Division	el or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28	f. Location (Street a City or Town, State		l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Phy	vsician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occurred at the tin n and/or investigation, in my o	me, date and place, and pinion, death occurred	d due to the cause(at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
)	To the within common co	Z Y	29b. Signature and title of continer	lyon	29c. Licens	5 6 9 1 9		ate signed (Month, $3/08/0$	_
1	11			3. DOUEGA	HJ.			GAL	70 ms
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9	32. Registrar's Signature	4 South)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#17,18,22, per Inf, G841, 3/18/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 2, 2005 **Physician** Emma Edna Gottlied 3:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Prince George's Clinton 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Ye Feb 14, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√√XF 216 40 7110 T911 Yrs. **Director** 94 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No Directo Prince Maryland George Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 7520 Surratts Road or Items 23s. 20735 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give X Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Item any injury or other treumatic event, the Medical Event. Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💢 o ģ 3 √Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4th Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Karl Gottlied Geppert Emma Tohn Tohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gottlied / Son 7805 Woodyard Road, Clinton, Maryland 20b. Place of Disposition (Name of Place of Disposition (Name of cemetery, crematory or other place) March 9, 2005 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State ^ 4 □ Donation 5 □ Other (Specify) Washington National Cemetery Suitland, Maryland 21. Signatur of Funeral Sovice Licensee Alexandria Facility Lee Funeral Home, Inc 663301d · Strank Alexandira Ferry Road, Clinton, Maryland 20735 MO0257 110ms V 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final ARTERIOSC Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 the detached 9☐ Unknown 9 Unknown Š signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one 1 ☐ Yes 2 No Other: 2 1 Inpatient Ē 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 29c. License number D - 18545 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Philip Wisotsky,

0 9 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD 1207 Old Line Center #207, Waldorf, Maryland 20602-2567

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year MARCH 3 va 2005 ROSA HOLMES 11.56 AM N /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA, MARYLAND HOWARD COUNTY ff Under 1 Year If Under 24 Hrs. 8. Date of Birth May 10, 1931 5. Social Security Number **229–42–6176** 7. Age (In yrs. last birthday)
73 Yrs. **Funeral** 9. Birthpface (State or Foreign 1 □ M **X**□ F VIRGINIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or Items 23e or 28e-1 show traumatic event, the Medical Examinat must be modified at MD. HOWARD Director COLUMBTA 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8865 GOOSE LANDING CIRCLE 21045 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) HOUSEKEEPER TOURIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi ANDREW HOLMES MAGGIE PATTERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: If item 27 Is any injury or other trait once. OLIVER HOLMES-SON 5518 HILLWAY, CAMP SPRINGS, MD. 20746 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ST. JOHN BAPT. CH. CEM. 3/9/2005 Burial 2 Cremation 3 Removal from State WILLIAMSBURG, VA. ` 4 ☐ Donation 5 ☐ Other (Specify) WILLIAMSBURG, VA.
22. Name and Address of Facility 21. Sign ture of Funeral Service Licensee Latney's Funeral Home 3831 Georgia Avenue e. N.W. Washington, DC 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMON, A disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS zola Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit losmaium that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient Certification: To 2 ER/Outpatient 3 DOA 27 NO this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No after death Director: / 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 53150 MD MARCH 450 ZOOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sute 110 21095 GULT A Registrar

			For State Registrar	State	of Maryland /	-	artment of H				_	2005	0787
			Decedent's Name (First, Middle	le, Last)			timodio or i			2. Date of De			3. Time of Death
Н	Physicia		Leona Stone Ho	olt Holder	-					Hebrua	rv 3	, 2005	11:07 PM
	/Medic Examin		4a. Facility Name (If not institutio				4b. City, Town, or	r Location				County of Death	1
			Caton Manor Nu	irsing Hom	ae		Balt:	imore					
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	B. Date of Birt (Month, Da	h y, Year)	9. Birth Cou	place (State or Foreign intry)
	Director		238-36-8489 Usual Residence of Decedent	1□ M 2□ F	89	Yrs.				Setp.	3,19	15 North	n Carolina
	land ow		10a. State 10b. County	/	10c. City, To	own or Lo	cation						10d. Inside City Limits
	Man 9-f sh	ţo	Maryland		Ba1t	imor	e City						1 🛣 es 2 🗆 No
	in the	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Cou	intry?
	ath wi		3333 Wilkens Av	venue			21229				Uni	ted Stat	tes
	tems	Funerai	11. Marital Status	Armed F		13.	Was Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	-	14. Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23a or 28e-f show ant, the Medical Examination must be notified at	by F	1 ☐ Never Married 2 ☐ Mar 3 🗶 Widowed 4 ☐ Divorced	If Yes G			1 □ Yes 2 □ X No	Specify:				Specify: W	nite
8	thou sture	ed		nt's Education		6a. Deced	dent's Usual Occup	ation			16b. Ki	nd of Business/li	ndustry
212	hin 72	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during mos d)	t of working	7			,
21	d wit	Com	3	00090		Pro	duction V	lorke:	r			Textile	e_Mill
p	be file	Be (17. Father's Name (First, Middle,	•						First, Middle,	Maiden	Sumame)	
yla	2 should I and Meni Is marked	은	William Holde					Mag	ggie	Reed			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Exercited must be notified at once.		19a. Informant's Name/Relations		1	9b. Mailir	ng Address (Street	and Numbe	er or Rural	Route Numbe	er, City o	r Towπ, State, Zi	^{p Code)} 27330
	1 and Health 6m 27 ther tr		Robert Stone, 20a. Method of Disposition	Son	20b. Place	214 of Dispo	Arlingtor	Circ	cle,	Sanfor	d, N	orth Car	rolina
altimore,	Pages nent of nnt: If it		1 XBurial 2 Cremation		State ceme	itery, crer	natory or other plac	(e)	Feb. 9	2005			,
	artme orten injun		' 4 □ Donation 5 □ Other (S		ropiar		gs UMC Ce		•				n Carolina
Ã	permit. Departr Importe any inju		· LUIDING	MA	M01113		09 Cartha						
			23a. Part1. Enter the disease, o shock, or heart faill re. Lis	r complications that	caused the death. D								Approximate Interval Between
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	/Medical		resulting in death)	Due to	(or as a consequence								0.10
	Examiner		Sequentially list conditions,	b									
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687	ificate g phy as the	edic		0.									
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	death	sicia	in the past 12 months? 1 Yes 2 No		birth 2 Fetal dea mant at time of death		Ectopic pregnancy Other (specify)					Month	Day Year
P.0.	that the de led by the a detached f	hys	9 Unknown										
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Vital Records,	ne law nhas b ge 2 sl	Completed								24a. Was autop	οsγ	prior to co	opsy findings available ompletion of cause of
al										1 Yes	rmed? 2 No	death?	21X No
Z.		Be	25. Was case referred to medical examiner?	Hospital:			. act pos. Oth	- 1		Check only o			
ot	Phys r this aral di	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	of Injury 28t	Outpatien o. Time of	T 3L DOA	4 XNL		e 5 □ Resid d. Describe h		Other (Special occurred)	fy)
on	Attending of death. sector: After by the funer	atior	Natural 5 Pendi	ng (Moi igation	nth, Day Year)	Injury	Wor	k? Yes 2□			,	,	
Division	l or Attendi after death. Director: A in by the fu	iffice	3 Suicide 6 Could 4 Homicide determ	nined 286. Plac	e of Injury - At home, ding, etc. (Specify)	, farm, str	eet, factory, office		28	f. Location (S City or Tox	Street an	d Number or Rur	al Route Number,
ō	tel or A	Certification:	- Tronslado	build	zing, etc. (Specify)					City of You	VII, SIAIO	,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	(Uneck only 2 Medical	ng Physician: To th	e best of my knowled basis of examination	dge, death	occurred at the tin	ne, date an	nd place, an	d due to the	cause(s)	and manner as	stated.
	the hin 2 the mplet	Med	une)	and mai	nner stated.								
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1	1-1X	1	30. Name and address of person	who completed and	JU'' U) .	a) (T	DO O	70 A	2 1	1	tbr	20 ARY	17 2005
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	Registr	ar	MAR 0 9	2005	ew &	A.	soli						

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ORIGINAL

			1- State of Maryland / Departn Certific	ment of H	ealth and Death	d Menta		ene (05	07878
q	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Carolyn Sue Hartman			2. Date	of Death	Day	Year	3. Time of Death
-	/Medic	cal		01. T	Landing (B)		arch	/	2005	5/3PM
	Examin	ner	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice at Mercy	. City, Town, or Baltir		atn			unty of Death timore	City
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year	If Under 24 H		of Birth			place (State or Foreign
٠,	Director		114-43-4322 10 ALS	onths Days	Hours Mi	Ma	nth, Day, 1	194	3 Wash	ington, DC
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on				-	1.	10d. Inside City Limits
	Mary -1 eho	tor	MD Howard Dayton							1 □Yes 2X No
	h the or 28a a rouli	Director		Of. Zip Code			100	g. Citizen	of What Cou	ntry?
	23a c	alD	14492 Triadelphia Mill Road	2103	36			US.	A	
	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I Armed Forces? If Yes	Decedent of His s, specify Cubar	spanic Origin? n, Mexican, Pue	(Specify Ye: erto Rican, e	s or No-		Race - Ameri Black, White,	
30	irs aft	by F	1 Never Married Married 1 Yes 2 Mo If Yes, Give 1 Year or Dates:	Yes 2 No	Specify:			Spe	ecity: W	hite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-1 ehow event, the Medical Evanfrar must be rodified at	ted	15. Decedent's Education 16a, Decedent's	s Usual Occupa	tion		16	Bb. Kind o	of Business/In	dustry
7	ithin 7 ne. nen "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	of work done di IOT use retired)	uring most or w	vorking				
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and	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-1 show atmatic event, the Medical Examinar must be notified at	o Be	Floyd Willis, II		18. Mother's N	F1orer			name)	
چ	should I	²	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	idress (Street a					wn, State, Zip	Code)
	es 1 and 2 should to of Health and Ment fitem 27 is marked rother traumatic e		Mr. Howard F. Hartman (Spouse) 14492 T							
ore	of He of He If item or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, crematory	n (Name of ry or other place	9)	Date	20	c. Locati	on - City or To	own, State
Baltimore,	Pages tment of tant: If it	J	`4 Donation 5 Nother (Specify) Entombment Crestlawn M			7/2005				ille, MD
g	permit. Pages Department of B Important: If ite any injury or of		21. Signature on Funeral Service Licensee Pulan L. Half Syke	me and Address GHT FUNF esville,	s of Facility ERAL HOI MD 21	ME & C 784 (4	HAPE 10)-	L, P	A. (Bo	ox 195)
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	100	Cun	cer				Onset and Death
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	cuted nd ransit	Examiner	that initiated events C.							
Ď,	oe exe cian al urial-t		resulting in death) Last Due to (or as a consequence of):							
9/8	the death certificate be executed y the attending physician and tched for use as the buriat-transit	dlcal	d						-	
o S	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	-				334	Date of delive	
ŭ	death e atter d for u	clar	in the past 12 months? 1	opic pregnancy er <i>(specify)</i>					Month	Day Year
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r		Com				1 🗆	performe Yes 2	d'	death?	
Vital	sician: certific irector,	Be (25. Was case referred to medical examiner?		26. Place of De	eath (Check	only one)			
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0	nding Phy th. : After thi s funeral o	tlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	28c. Injury Work I 1 TY	es 2 □ No	200. 200	ICTIBE TION	injury oc	carred	
DIVISION	Atter	Certification;	3 Suicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office			ation (Stree		mber or Rura	I Route Number,
5	itat or rs afte ral Dii	Cer								
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investiged and manner stated.	urred at the time gation, in my opi	e, date and place inion, death occ	ce, and due curred at the	to the caus time, date	se(s) and and plac	manner as st	ated. the cause(s)
	To t To t comp	N	29b. Signature and title of certifier	29c. License	number		29d	Date sig	ned (Month,	Day, Year)
A	11		P D N Im X m	D40.	854			31	2120	05
(0		30 Name and address of person who combleted cause of death (Item 23a) (Type, Print)	UL PI	Bal	din	Ove	ma	1. 21	202
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 200	for						

amend item#22, per Frin G841, 3/9/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year CORNELLA HARROD **Physician** MARCH 2001 10; 45AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Northwest Hospital 401012 Court R. Ra Himove 7. Age (In yrs. last birthday) & Yrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 213-34-8798 1 ☐ M 2 💢 F MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23a or 28a-f show the Medical Examenar must be notified at MD Baltimore 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road filed within 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: Back 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College, (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12th arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 Is marked ott Jury or other treumatic even Mason Elmer Beulah C. Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stamford Baltimore, MD 21229 Hamod Jerome C. 12d. 20b. Place of Disposition (Name of cametery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD permit. Page Department o Important: If any injury or once. Cedar *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungal Service License 2, Name and Address of Facility Vaughn C. Greene Funeral Services 551 Baltimore National Pike Balto. SMD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METAGTATIC LUNG CA Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit o the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Cther (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 4 hours after death. Funaral Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 6, 2005 30. Name and address of rerso / Completed cause of death (Item 23a) (Type, Print) AID 31. Date filed (Month, Day, Year) State MAR 0.9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Dea	, 0	. No.
	Dhysiolan	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth	Dey Year 3 Time of Death
e de la companya della companya della companya de la companya dell	Physician /Medical	Catherine A. Henson	March	7 2005 2355
and the	Examiner	A	y, Town, or Location of Death	4c. County of Death Baltimore
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	Funeral Director	219.98.570 1 M 25 F 89 Yrs. Months Days Hou	nder 24 Hrs. B. Date of Birth (Month, Day, Y.)	9. Birthplace (State or Foreign Country)
	pu *	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	r 28a-f short notified at	MD Baltimore Baltimore		1 ☐ Yes 2 ☐ No
	or 28a-f show	10e. Street end Number 10f. Zip Code		. Citizen of What Country?
	th w		207	USA
	ter dea	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Merical 1 Ye	ic Origin? (Specify Yes or No- ixican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
020	urs eff	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Spe 1 ☐ Yes 2 ☑ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Y	ecify:	specify: Black
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours e Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", on any injury or other treumatic event, the Medical Examing injury or other treumatic event, the Medical Example.	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	most of working	b. Kind of Business/Industry
121	filed within Hygiene. Ther than "ther than "ont, the Max	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		Food Service
	filled v Hygie ther t	12th grade N/A 17. Fether's Name (First, Middle, Last) 18. M	Mother's Name (First, Middle, Ma)	
Maryland	Mental Mental	A	Tohnanna 6	1 00
ary	2 should and Misman	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No	umber or Rural Route Number, C	ity or Town, State, Zip Code)
	end 2 ealth n 27 i	Floyd Henson /Son 1144 New Aiela	1 200111	more MD 21207
Baltimore,	Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. Int: it it is marked other than ity or other treumatic event, the Me	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		C. Location - City or Town, State
Ħ	permit. Pa Departmen mportant: any injury	4 Donation 5 Other (Specify) 21. Signatuse of Funeral Service Licensee 22. Name and Address of F		Baltimore MD
Ba	permit. Departr Imports any inje	Vaugh C. Gr	eene Funeral S	Senines Le Balto. MD 21229
	*	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heartfailure. List only one cause on each line.	th as cardiac or respirelory arrest	Approximate
	Physician	snock, or neart failure. List only one cause on each line.		Interval Between Onset and Death
and the	/Medical Examiner	Immediate Cause (Final disease or condition		years
ı		resulting in death) Due to (or es a consequence of):		
	executed in and ital-transit	Sequentially list conditions Due to (or es e consequence of):		İ
o,	requiras thet the death certificate be executed seen signed by the attending physician and hould be datached for use as the bunal-transit eted by Physician/Medical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		
68760,	ficate be physicials the bur	Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of):		
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P.O.	by the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P		cco use contribute to the cause of death? 2□ No 3⊕Probably 4□Unknown
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ord	v requiras thet tha daath cebeen signed by the attendit should be datached for use deted by Physician/I		24a. Was an a performed	d? available prior to
Records,	aw Is b		20000000	completion of cause of death?
a	cartificate hirector, pega		1 □ Yes	2 No 1 ☐ Yes 2 ☐ No
of Vital	Physician: this cartific ral director,	examiner?	Place of Death (Check only one) Nursing Home 5 Residence	o 6 Other (Specify)
	g Physic er this coneral dire	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury et	28d. Describe how	
sior	Attending or deeth. Ctor: After by the fune	2 ☐ Accident investigation M 1 ☐ Yes 2	2 🗆 No	
Division	or Attendanted or Att	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	nt and Number or Rural Route Number, State)
		29a. Certifier 125-Certifying Physician: To the best of my knowledge, death occurred at the time, date	te and place, and due to the caus	e(s) and manner as stated
	To the Hospital within 24 hours a To the Funeral I completaly filled Medical Ce	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at the time, date	end place, and due to the cause(s)
_	withir comp	29c. License numb	ber 29d.	Date signed (Month, Day, Year)
	1 N		15 15	March 8,2005
	1/11	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sef Zhoell MD 25 Mark St. Reste	arten MT	21/36
	State	31. Dete filed (Month, Day, Year) 32. Registrer's Signature	CIZVEN 341V	01136
6.1	Registrar	MAR 0.9 2005		

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ONSTANCE EVELY TARDING MARCH OF 100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner County General Columbia Havara Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213.36.1003 1 ☐ M 2 🔀 F LOLO Yrs. Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at Howard MD Director 1 ☐ Yes 2 No VESSUP 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? 8213 Drive 20794 Lincoln Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 258 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Howard County other than " College (1-4or 5+) Elementary/Secondary (0-12) Public Schools server 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked out Bennett James Dzno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Hardina/Husband 8213 Lincoln Jessup MD 20794 Walter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Jamson Forest * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Licensee 22. Name and Address of Facility Vaughn. C. Greene Funeral Services 5151 Baltimore National Pike Baltimore au Baltimore MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) NY Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Be Completed by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ies 2 □No Day Month 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ENCEPHA 2 No 3 Probably 1 🗌 Yes TENSCUM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Vatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by 4 THomicide within 24 hours a To the Funerel E To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MNC6 07 7005 horcompleted cause of death (Item 23a) (Type, Print) sult Durie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 9 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 453PM LILLIAN L. HASSON 2005 Marc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner City, Town, or Location of Death fartord Haure De Grac TOME iTiZens LTS119 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 1 Yrs. Director 212-26-1397 79 10/6/1925 Maryland | Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28a-f show the Medical Exercine must be notified at 1 Yes 2 No MD Harford Darlington Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2131 Glen Cove Road 20034 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event 9088. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Charles Benjamin Lee Bertha Flowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Hasson, Jr./Son 2131 Glen Cove Road, Darlington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery |3/5/2005 Darlington, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WIMM ARY **Physician** EMI3011SM /Medical Que to (or as a consequence of) Examiner TRIDION YOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consec Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): NIPAGE OKS Men who Physician/Medical Way in me IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) ned by the a edetached f 9 Unknown been signed by should be detac Part IJ. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Honknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performe After this certificate I 1 Yes 21 No To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ٩ 1 ☐ Yes. 2 No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d, Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No nerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only Medical 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 SIM M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 SWD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARKCH Physician 2025 01:00 AM Billy Joe Hilton /Medical 4a Facility Name (If not institution, give street and number) Baint Joseph Medical Center 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 F Days Yrs. Director 410 34 1124 November 15 1926 Rogersville, TN. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or iteme 23a 21234 1830 Trenleigh Road USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or item ony injury or other traumatic event, Ita Menters Exercises. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced WIIWhite 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NΑ Self Employed Hilton Cleaners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joe Hilton Gladvs Preslev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor M. Hilton 1830 Trenleigh Road Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery March 10 2005 Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home, Inc 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISCHEMIC HEART DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760,< Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XYes 2□No 3□Probably 4□Unknown Completed ACUTE RENAL FAILURE PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Tes 1 Tyes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investination in my opinion, death accurred at the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of signed (Month, Day, Year) 29c. License number 29d, Date D 24034 30. Name and address of person who completed/cause of death (Item 23a) (Type, Print) LOW M. D 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Physician AVIE Hudson Month Year March 3Am 2005 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth KESWICK MULTI CARE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Yeer) **Funeral** Birthplace (State or Foreign Country) Days 206-05-7332 1 M 2 □ F 90 Director 08/13/1914 VIRGINIA Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar main be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 □ No BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 100 B RIDGEWOOD RD Funeral 21210 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Š Specify: WHITE 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ENGINEERING ENGINEER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES B. HUDSON LOUISE WELLS BOLINGER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) KATHARINE HUDSON (DAUGHTER) 100 B RIDGEWOOD RD BALTO., MD 21210. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GREEN MOUNT CREMATORY 03/09/2005 BALTO. CITY, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility HENRY W. JEMKINS & SONS CO. 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Examiner or Attending Physician: The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): CANCER Division of Vital Records, P.O. Box 68760 STATE Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? USTEVAYTH RITIS 2 1 No 1 Yes 3 Probably 4 Unknown ģ Be Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 🗆 Yes 212 No 1 ☐ Yes 2 ☐ No After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 201No Other: Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29a. Certifier Medical within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) MI MArcit 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type Print) 104 lun bv. dae KUAD 1) 31. Dete filed (Month, Day, Year)
MAR 0 9 2005 32. Registrar's Signature State Registrar

			For	State of Marylan	id / Depa	artment of H	lealth and	Mental Hy	giene	do and	
		4	For State Registrar AMEND ITEM 1. Decedent's Name (First, Middle, Last)	# 18 PER FH (2841 CR	tificate of	Death		Reg. No.	05	07885
	9		1. Decedent's Name (First, Middle, Last)	# LO LLEX THE	11	LUFUZ UII		2. Date of De	ath Day	Voor	3. Time of Death
	Physicia /Medic		Rupy	1	Hale			March	01 0	2005	0304 AM
	Examin		4a. Facility Name (If not institution, pive s	street and number)		4b. City, Town, or	r Location of Dea		4c. Count	y of Death	
			Bayvill Medica	y center		DALT	more				
	Funeral		5. Social \$ecurity Number 6. Sex	M STORE	last birthday): Yrs.	Months Days	Hours Min	. (Month, Da	th ay, Year)	Countr	
	Director	}	228-60-4710 Usual Residence of Decedent	58	113.			NOV. 2	4,1946	Virg	jinia
Jand	Mo to		10a. Slate 10b. County	10c. Cit	ty, Town or Lo	cation			-	10	d. Inside City Limits
Ma	il in	to	Maryland Baltim	ore			:	Dundalk			1 ☐ Yes 2 No
h the	or 282	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	y?
Ę.	23a (1247 South 48th	Street		212	222		Unite	d Stat	es
r dea	tams ar m	Funeral		12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No rto Rican, etc.)		ice - America ack, White, et	
.0036 hours after death with the Maryland	ital Hygiene. ad othar than "natural", or Itams 23a or 28a-f ehow avant, It'e Medical Examinar must be nutified at	by F	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Speci	ify:	_
	ttural E E	edt	15. Decedent's Edu		16a, Dece	dent's Usual Occup	ation		16b. Kind of I	Whit Business/Indu	
21215-0036	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo	orking			,
2121	r than	E O	Elementary/Secondary (0-12)	2 Years	R	egistered	d Nurse		Health	Care	Provider
und 2	al Hygi I othar vant, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle HOR)	, Maiden Surna VR	me)	
arylaı	nd Mental markad c matic ava	To	Troy Dingus				Kisting.	itha Har	ne		
-	and s m		19a. Informant's Name/Relationship (Ty Robert E. Hale,		1	ng Address <i>(Street</i> 7 South 4					
	m 2 m 2					sition (Name of	toth Str	Date Bal	20c. Location		and 21222
Baltimore,	0		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ F	lemoval from State	cemetery, crei	natory or other place	1 .				
Itim			*4 □ Donation 5 □ Other (Specify) 21. Signa r f Funeral Service Licens		-	ill Mem.		•		ewood,	
Balt	Depar Impor any ir		E Como E	Part -	Ď	2. Name and Addre uda – Ruck	Funeral	Home of	Dundal	k, Inc	
			23a. Part1. Enter the disease or compleshock, or heart failure. List only or	ications that caused the dear	th. Du not ent	922 Wise er the mode of dying	Ave Di ng, such as cardia	undalk, ac or respiratory a	Marylan rrest,		Approximate
			Immediate Cause (Final	ne cause on each ine.	Klerk	Maria					Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death)	aDue to (or as a) consét	uence of):	Marie IC	-	Divini	_		40.00
E	xaminer	ш	0	Mixed (DUNEC	till li	SSUP	DISPUS	2		
	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conser	quence pf):	1 . 1	nymaca				
V	ind trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	. THEISHIT	ial	lung 1	11seuse				
38760, <	physician and the burial-transit	<u>E</u>	rosaling in dozin, east	Tue to (or as a consec	quence or):	O_{\odot}					
		dlcal									
9 X	attending for use as	Physician/Me	IF FEMALE:	23c. If yes, oulcome of pregn	ancy				23d D	ate of deliver	v
Box 6	atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Feta 4 Pregnant at time of a	al death 3	Ectopic pregnancy Other (specify)	<i>y</i>				Day Year
0	ned by the a	hysl	9 Unknown	9□ Unknown							
٦.	nie law requires inat ule ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions co.	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use coi	ntribute to the	cause of death?
Records,	an sig							10	Yes 2□No	3 🗌 Proba	bly 4 \Unknown
000	has been ge 2 should	plet						24a. Was		. Were autop:	sy findings available pletion of cause of
		Completed						perf	ormed? 2 No	death?	Piction of cause of
Vital	rilysiciani. Ili this certificate ral director, pag	Be (25. Was case referred to medical examiner?					eath (Check only	one)		
of V	dis S	2	1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🗖			4 Iduising	Home 5 ☐ Res			
	ffer fine	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occu	ırred	
Sic		cat	2 Accident investigation 3 Suicide 6 Could not be	Ogo Plana of Injuny At h	iomo form et		Yes 2 □ No	29f Location	Street and Num	thor or Pural	Pouto Number
~	2 2 2 5	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	eet, ractory, onice			wn, State)	ibei oi nuiai	noula ivumber,
_	o the nospital or attent within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 To Certifying Phy	sician: To the best of my kn	owledge, deat	h occurred at the tir	me, date and place	e, and due to the	cause(s) and n	nanner as sta	ted.
	a Full	Medical		ner: On the basis of examination and manner stated.							
1	withir To th	Me	29b. Signature and title of certifier	//	1	29c. Licens	se number		29d. Dale sign	ed (Month, D	Pay, Year)
)			> House	tant 1	ND	1)3	1091		03/0	1/200	25
	عدائ		30. Name and address of person who	ompleted dause of death (Ite	m 23a) (Type,	Print)	Ano	Dil An n	1: 00	114	2,201
	10		Howard W. Mah	paman, M.D	100	io east	CHIM	EO WW	AMORE	,10	71900
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 9 20	32 Hegistrar's Sign	ature	7/10	1 44				

DHMH 17 Rev 1/2001

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			For Stete	State of K	-	e rtificate of			2000	07007
			Registrer 1. Decedent's Name (First, Middle,	Last)		ortinoate or	Death	2. Date of Death	g. No. UUJ	3. Time of Death
	Physici		0 64	11.				Month	Day Year	1:45 P M
	/Medic Examin		4a. Fecility Name (If not institution,	give street and number	r)	4b. City, Town,	or Location of Death		4c. County of Deatl	
1	LAdillii	C1	Riverview Nurs			Esse				ore Co.
	Funeral			S. Sex 7. A	ige (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		nplece (State or Foreign untry)
	Director		218-22-8596	1□M 2只F	89 Yrs.	Months Days	Hours Min.	Jan. 15,	1916 Ma:	ryland
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Lacation				104 1-14-05-11-5-
	sho	ក	Maryland	N/A	TOC. City, TOWITO	Location	T T	Baltimore	City	10d. Inside City Limits No No
	the N	ecto	10e. Street and Number	N/ A	1	10f. Zip Code				
	with	급		7		Tot. Zip Code	2122		g. Citizen of What Co	
	seath	Funeral Director	949 Quantril W	12. Was Deceder	nt Ever in U.S.	3. Was Decedent of	2120		United S	
(0	riter of	Fu	1 ☐ Never Married 2 ☐ Marrie	Armed Forces d 1 ☐ Yes 2-2	?]No	B. Was Decedent of If Yes, specify Cub		o Rican, etc.)	Black, White	
9	ral', o	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates	:	1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Examiner must be notitled at	Completed by	15. Decedent's (Specify only highest		16a. De	pedent's Usuaf Occu ve kind of work done DO NOT use retire	pation	king 1	6b. Kind of Business/I	Industry
21	nithin De.	npi	Elementary/Secondary (0-12)	Coffege (1-4o	r 5+)	. DO NOT use retire	nd)			
	led w tygier her ti		Ukn.		P	ssembler	1 12 14 11 1 11		Bendix Co	orp.
and	tal H	Be	17. Father's Name (First, Middle, La					ne (First, Middle, Mi		
2	d Mer mark	잍	William 19a. Informant's Name/Relationshi	Wilkinso	-	ilia - Addana (Char		largaret I		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.		Mrs. Charlotte			0 Bayside			City or Town, State, Z , Maryland	
	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla			oc. Location - City or	
ē	ages ant of nt: If i		1 Burial 2 Cremation 3	B □Removal from Sat	or w	rematory or other pla hedral Ce			Baltimore	
Baltimore,	artme ortan injur		21. Signature of Funeral 3 my ()		Julew Car	22. Name and Addr	ess of Facility			-
ä	permi Departimpo any ir		1/4/101	1 42/1		Duda-Ruc	k Funeral	Home of Dundalk,	Dundalk, :	Inc. 21222
	-		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	of the death. Do not	enter the mode of dy	ng, such as cardiac	or respiratory arres	st,	Approximate fnterval Between
	Physician		fmmediate Cause (Finaf disease or condition	(1)	aceta					Onset and Death
	/Medical		resulting in death)		is a consequence of):					
1	Examiner		Sequentially list conditions	b						
A	ted red	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.	Due to (or a	is a consequence of):					
B	and -tran	каш	that initiated events resulting in death) Last	C. Due to (or s	is a consequence of):					
760,	icate be executed physiclan and s the burial-transit	cai E		000.00	o a consequence on.					
687	w requires that the death certificate been signed by the attending phys should be detached for use as the			d						
Вох	certifica nding ph use as th	N/M	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		_			23d. Date of deli	verv
	death e atten	icia	in the past 12 months?	4□Pregnant	at time of death	B□Ectopic pregnanc B□ Other <i>(specify)</i> _	У		Month	Day Year
P.0	t the by the	Physician/Med	9 Unknown	9□ Unknown						
	requires that the een signed by th nould be detache	by P	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
bro	equir sen si ould	ted	Colorand Hr.	tery Dis	rane			1 ☐ Yes	2 □ No 3 □ Pro	bably 4-dinknown
Records,	lawr as be	Completed	Hypotypoid					24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
<u>=</u>	The law cate has	Con						performe 1 ☐ Yes 2 ∫	ed? _ death?	2 No
Vital	ding Physician: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Heavitals				th (Check only one)		
of	Phys this al dir	- To	1 Yes 2 No		tient 2 EP/Outpat	BILL JUDA			ce 6 Other (Spec	ify)
O	fter	tion	1 ☐Natural 5 ☐ Pending		Day Year) 200. Tille	/ Wo	rk?]Yes 2□No	28d. Describe how	injury occurred	
Division	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could no	ot be	njury - At home, farm,		,	28f. Location (Stre	et and Number or Ru	ral Route Number.
Š	a or a after	Certification:	4 Homicide	building,	etc. (Specify)	, ,,,		City or Town,	State)	
	ospita hours unera ly fille	Saic	29a. Certifier 1 Certifying	Physician: To the bes	st of my knowledge, de	ath occurred at the t	me, date and place.	, and due to the cau	ise(s) and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	une)	xaminer: On the basis and manner	or examination and/or stated.	investigation, in my	opinion, death occur	rred at the time, dat	e and place, and due	to the cause(s)
	To To	Σ	29b. Signature and title of certifier	lin.		29c. Licen		290	d. Date signed (Month	, Day, Year)
	_		1 Crease	Common			9667	t	307- 2	2005
	2	20	30. Name and address of per on w				A Masser 1	and 2106	1	
		•	Michael Schwarts 31. Date filed (Month, Day, Year)		trada Cianatura	Glen Burni	Le, Maryla	ZIIU ZIU6.	<u> </u>	
:	Sta Registi		31. Date filed (Month, Day, Year)	005	a Maria Signature	we				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No: 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 4 = 14 9 M **Physician** Joseph 2005 Hartman March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Baltimore Johns Hopkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**3 M 2□ F 71 Director 219-28-2979 Aug. 8,1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental hygiene. ant: if item 27 is marked othar than "natural", or Itema 23a or 28a-f show ary or othar traumatic event, it a Medical Examilinar matter in all find at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Baltimore City 1 TXYes 2 □ No Maryland N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 United States 5006 East Preston Street Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 21211No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dry Wall Mechanic Construction 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Winifred A. Hughes ပ Phillip H. Hartman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5006 East Preston Street Baltimore, MD 21205 Mrs. Marion Hartman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or once. Service Corp. 3/11/2005 Towson, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) *i*lltop 21. Signature Vineral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart Priysician hours /Medical Due to (or as a consequence of) Examiner pul monarn Sequentially list conditions, if any, loading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last this to (or as a nonsequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Sepsis Due t (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Pulmonary Obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 2X No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 12 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After 1 Certification: 1 Natural 2 Accider 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No Accident in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ben Res-000 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Avenue Balfimore Bar Eastern Tina 31. Date filed (Month, Day, Year)
MAR 0 9 2005 32. Registrar's Signature State La Stand Registrar

			For	State of Maryland /	Department of Health and I	Mental Hygier	те	
			1 - State Registrar		Certificate of Death	Reg. I	No. 2005	07880
	Physicia	an	1. Decedent's Name (First, Middle, Last,	- Hamm	T	2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deatl	march	4c. County of Deat	h
	LAGITIM	·	825 Thurn	ian Ave.	Hvattsvill	le 1	rince	Georges
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last b	oirthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent	52	115.	12-14-19.	52 V	irginia
	nyland how		10a. State 10b. County	10c. City, Tox	wn or Location			10d. Inside City Limits
	8e-f s	cto	Maryland Prince	Georges Hi	jatts ville			1 XYes 2 □ No
	with the	Dire	10e. Street and Number	A.10	10f. Zip Code	10g.	Citizen of What Co	untry?
	ms 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	ncan Indian,
ي	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White	e, etc.
21215-0036	within 72 hours after death with the Maryland ene. Then "naturel", or Items 23e or 28e-f show the Medical Exeminer must be rediffed at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	/ /		Specify: B	lack
15-	in 72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	 Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 	king 16b	. Kind of Business/	Industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Accountant		omme	ercial
	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last)	11	18. Mother's Nar	ne (First, Middle, Maid	en Sumame)	
Maryland	shoutd I nd Men n marke umetic	얼	beorge E.	Hamm Sr	- Louc	inna	White	2000
Mai	id 2 st th and 27 Is n treun		19a. Informant's me/Relationship (T)	pe, Print) Broker) 19	Db. Mailing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, 2	Zip Code) 20905
re,	is 1 and of Health item 27 other to		20a. Method of Disposition		of Disposition (Name of lery, crematory or other place)	Date 20c.	Location - City or	Town, State
<u>i</u>	Pages ment of ent: If it ury or c		1 ☐ Burial 2 X Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State	n Mount Cromatory 3/8	3/2005 F	Balto.	Md.
Baltimore,	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23e or 28e-f show appring to other treumetic event, the Medical Examination at any injury or other treumetic event, the Medical Examination at any injury.		21. Signature of Funeral Service Licens	4 Dina	22. Name and Address of Facility	Tineral	Home	
	40364		23a, Part / Enter the disease, or compl	ications that daused the death. Do	o not enter the mode of dying, such as cardiac	Balto.	Md. 213	Approximate
	Physician		Immediate Cause (Final	LONG 657IV 6	LIKART PASLURE	or toophatory arroot,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	7701 11-1			374
	Examiner		Sequentially list conditions, if any, leading to immediate	o				
	pet tisu	nine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a consequence	e of):			
Ć.	execuin and ial-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	e of);			
8760,	cate be executed physician and the burial-transit	dicai		1		<u></u>		
9		a)	IF FEMALE:	220 If you subsequent and accompany				
Вох	eath certific attending p I for use as	cian	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year
O.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	o a cardi (aposity)			
s, P	The law requires that the death certifi tte has been signed by the attending tage 2 should be detached for use as	by Р	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	w requir been si should	eted	17,100,0			1 🗆 Yes	2 ₩No 3 Pro	obabiy 4 Unknown
Vital Records,	has b	Completed	MANZEHEMIZE CAPA	DWALLING DOUSE	TES-MOUTMS,	24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of
tal		e Co	25. Was case referred o medical		26 Place of Dec	th (Check only one		20/No
ſΥ	d is: 🗶	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Other	ome 5 Residence	6 □Other (Spec	cify)
n of			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b.	. Time of 28c. Injury at Injury Work?	28d. Describe how in		
Division	Attending or death. rector: Afte by the fune	Icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	M 1 Tyes 2 No	28f. Location (Street	and Alimbert Or O.	um l Courte Alium hou
Σ	ol or Atten after deatl Director: d in by the	Certification:	4 Homicide	building, etc. (Specify)	Tarrit, Street, lactory, office	City or Town, St.		rai nobie ivuitibei,
	To the Hospitel or I within 24 hours after To the Funerel Dire completely filled in b		29a. Certifier 1 Certifying Plyy	sician: To the best of my knowled	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause	(s) and manner as	stated.
	To the H within 24 To the F complete	Medical	29b. Signature d title of partic	and manner stated.	29c. License number		and place, and due Date signed (Mont)	
	T S S	7/	255. Signature do title of teach	THIMAS LAKELY	VIIIZZ J. License uninper		3.08.65	i, vay, rear)
	1//			ompleted cause of death (Item 23a	(Type, Print)			
(/ _		Thring I'M MODE	al 54576ms s	SOIR YORK Rd. BALTA	MUP-6 Md.	4171	
	Sta Registr		31. Date filed (Month, Day Year) MAR 0 9 200	2. Registrar's Signature	died)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Velma R. **Physician** Hunley 10:52 A M 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner md Ko etu town Chester River Manor If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 68 Sept.13,193 Director Md. 214-34-7294 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or Items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at 1x Yes 2 □ No Rockhall Director Kent Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21661 21394 Brittany Bay dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2√☐No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Completed by 3 Widowed W Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 le marked other than Elementary/Secondary (0-12) College (1-4or 5+) general laborer construction llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Chism Donald r. Hunley ပ 19a. Informant's Name/Relationship (Type, Print)
Pamela Hunley / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21394 Brittany Bay dr. Rockhall, Md. 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State = 5 Christian Chapel Mar.5,2005 Worton, Md. permit. Page Department of Important: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith F.H. 426 E. Dover st. Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Curlisses disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Faller 1 Yes 2 1 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has autopsy performed? (es 2 No 3) 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ENatural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 221313 2/28/05 1. Ulum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 415 Washington Aue, Clastertown, MD 21620

Registrar DHMH 17 Rev 1/2001 K. WUN

MAR 0 9 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of M	arylan		artmen rtificat			d Mental I	Hygien		-	78	91
H	Physic	an	1. Decedent's Name (First, Middle, La							2. Date of Month	Da			3. Time o	
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	ith the Marylan or 28a-f ehow	ţō	MARYLAND N/A			BAL	TIMOR	E						XXYes	2 🗌 No
	th the	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. C	tizen of What	Count	ry?	
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	er dee	nue	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Deced If Yes, spec	lent of His	spanic Origin' n, Mexican, P	? (Specify Yes or uerto Rican, etc.	No-	14. Race - A Black, W			
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed	1XXYes 2 ☐ If Yes, Give Year or Dates:	42/45	5	1 Yes	X No	Specify:			Specify: E	LAC	K	
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Baltimore,	permit. Pages 1 a Depertment of Hee Importent: If item any Injury or othe		21. Signature Funeral Service Lice	nsee		M		M C	s of Facility BROWN TH AVE	COMMUNI:	ry Fun	NERAL H	IOME	E P.A.	
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Vital	clan: ertific ector,	Be	25. Was case referred to medical examiner?	11		/				Death (Check or	nly one)				
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Division	To the Hospitel or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At hor tc. (Specify,	me, farm, str			03 2 0 110		n (Street ar Town, State	nd Number or e)	Rural	Route Num	ber,
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			I Ven lu					77	9483	2	Mar	40	4,	2005	pa ³
1	+1		30 Name and address of person who	500	3on.	Sec	Print)	0 \$	Loop	ital	B	alto		mo	λ-
	Sta Regist		31. Date filed (Month, Day, Year) MAD 0 9 2005	32. Regist	ar s Signati	STATE OF THE PARTY	W		,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:50 llian 2005 na 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 214.40.6940 1 □ M 2 🖼 F MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanth at mast bu notified at MD Baltimore ('atonsville 1 Yes 2 No **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If them 27 is marked other than "--- any nighty or other traumest- any nighty or other traumest-USA Nesley Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BOCK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Howard County College (1-4or 5+) Elementary/Secondary (0-12) Custodian Schools 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gaither -loud SIR Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue atonsville MD 21228 Eugene N. Jones Husband Wesley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 03.11.05 Arbutus * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Voughn o. Greene Funeral Sensices
551 Baltimore National Pike Ba an Balto MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a cons ence of) Box 68760. Physician/Medicai the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown þ page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 ☑Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 1 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes 2 ☑ No 1 Minpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital

Medical completely within 2.

Registrar

Chudnosky , MD 31. Date filed (Month, Day, Year)

MAR 0 9 2005

(Check only one)

29b. Signature and title of certifier



Cardialisist/ Physician

Alexander Chandress

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Patrixent

Parkway Suit 101 Columbia, MD 21044

			1 - For State Registrar	State of Marylan		nt of Health and N te of Death	Mental Hygien	ZUUJ -	07893
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, La: North Al 4a. Facility Name (If not institution, give	V 1. Ju	HNSON 4b. City	, Town, or Location of Death	03/0	Day Year 6 / 2005 4c. County of Death	3. Time of Death
	Funeral Director	lei	COOD SAMAR 5. Social Security Number 6. S 212. 01. 8368			BACTIA er 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (May 28)	912 MA) in place (State or Foreign Man) Canal Ca
	ith the Maryland or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD •	10c. Cit	y, Town or Location BALTIMO	RE			10d. Inside City Limits 1 W Yes 2 □ No
	eath with the second se	Funeral Director	1915 E. LA 11. Marital Status	FAYEHE 12. Was Decedent Eyer in U.	AVE.	ip Code 2/2/3 edent of Hispanic Origin? (Sr		Citizen of What Cou	·A .
5-0036	n 72 hours after death with the Maryland "natural", or liems 23a or 28a-f show sidical Examinatin and be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 212 No Specify:	Rican, etc.)	Black, White,	
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_	s 1 and 2 sho of Health and Item 27 is my other traum		EDNA K. John 20a. Method of Disposition	SON / WIFE 20b. P	19b. Mailing Address Place of Disposition (Note that the second control of the second c	ss (Street and Number or Rule LA INEHE ame of other place)	AVE. B	Cocation - City or T	E,MD 21213
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	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions of		ulting in the underlying	cause given in Part I.	23e. Did tobacco	o use contribute to t	the cause of death? bably 4 □Unknown
Il Records,	The law ate has by page 2 sh	Completed					24a. Was an autopsy performed?	death?	opsy findings available ompletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	#BIG	Othor	h (Check only one)		
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Divis	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specif	y)		28f. Location (Street City or Town, Sta	ate)	
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	To the within Fo the	Mec	29b. Signature and title of certifier	and mainer stated.	2	9c. License number	29d. [Date signed (Month,	Day, Year)
	0 10	2	& S. Mamos	MD		00060687		03/06	12005
	4010		30. Name and address of person who		1 23a) (Type, Print) 560 (CO	CH RAVEN	BUD B	ALAMOR	ZE 21239
707	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture As Ase	رن			

DHMH 17 Rev 1/2001

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	Funeral Director		-	Sex 7. Age 1 ☐ M 2 【文字	(In yrs. last birt 88	Yrs. Months	Days Ho	nder 24 Hrs. urs Min.	8. Date of Bit (Month, Da	9. Bi 4, 1916 Ma	irthplace (State or Foreign Country) ryland
			Usual Residence of Decedent		00				Dec. 2	4,1910 Ma	ryrand
	irylan show	_	10a. State 10b. County Ma Balti	mara l	10c. City, Town	or Location	Dirrow			-	10d. Inside City Limits
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	with th	Dir	10e. Street and Number 109 Day Coach	Circle		10f. Zi	21220			10g. Citizen of What C	Country?
	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Examires must be notified at	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13 Was Dace		ic Origin? (Spe	wify Ves or N		orioan Indian
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68			IE EENAAL E								
Вох	ath ce tendir	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o		3 □Ectopic p	regnancy			23d. Date of de	•
0.	ne dea the al	/sici	1 Yes 2 No	4☐Pregnant at t 9☐ Unknown	ime of death	5 Other (s				Month	Day Year
P.0	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions of	ontributing to death but	t not resulting in	the underlying of	ause given in P	Part I	23e Did t	obacco use contribute I	o the cause of death?
Records,	uires I sign	d b	Macular decen		,	and anicony, any	acco given in	art i.			robably 4 Hunknown
00	w requir been si should	iete							24a. Was	an 24h Wara a	utoney findings available
Re	The la te has age 2	Completed							autop	rmed? death?	utopsy findings available completion of cause of
Vital	ian: rtifica stor, p	BeC	25. Was case referred to medical		<u> </u>		26. P	Place of Death			2 □ No
of V	Physician: this certificatal director, I	2	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Out	patient 3 DC	OA Other: 4 E	Nursing Hom	ne 5 ☐ Resid	dence 6 □Other (Spe	ncify)
	fter	OU:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		jury	28c. Injury at Work?		8d. Describe I	now injury occurred	
isio	or Attending I after death. Diractor: After in by the funer	icat	2 Accident investigation 3 Suicide 6 Could not b		A. h	M	1 Yes 2		01.1		
Division	after after Dirac	Certification:	4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At nome, fari (Specify)	m, street, factor	y, office	2	City or Tov	Street and Number or R. vn, State)	ural Route Number,
	spita hours neral y filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge,	death occurred	at the time, date	e and place, a	nd due to the	cause(s) and manner as	s stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	edical	(Check only 2 Medical Exar	niner: On the basis of e and manner state	examination and	or investigation	, in my opinion,	death occurre	d at the time.	date and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			290	c. License numb	per		29d. Date signed (Mont	
,	1		Turlearly a	Rismons		I	21966)		03-07-2	005
	10		30. Name and address of person who	i	ath (Item 23a) (T	ype, Print)	tchie	//	01	03-07-2 Bervie	146
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar				THE WY	U- 181	ruple 1	.0
	Registr		MAR 0 9	- M	as A	Asset					

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State of Maryland / Department of Health and Mental Hygiene 0 0 5

07895

						Certi	ificate of	Death			Reg. No.				
	Physici /Medic		Decedent's Name (First, Middle, La ANNA BOGDA'N	st) JANKALSKI						2. Date of De Month MARCH	ath Day	Year	3. Time of Death 9:22PM		
	Examin		4a. Facility Name (If not institution, giv 7916 Underhill R						wn, or Lo oseda	cation of Deat	th 4c. County of Death BAltimore				
į	Funeral Director		5. Social Security Number 217–07–8247 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. last birt		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 10-13-	th ly, Year) 1920	9. Birthp Cour Ma	olace (State or Foreign aryland		
	Maryland a-f show iffed at	tor	10a. State 10b. County	imore	10c. City, Towr	or Loca		edale				1	0d. Inside City Limits 1 ☐ Yes 2 ☒No		
	vith the	Funeral Director	10e. Street and Number	_			10f. Zip Code				10g. Citizen of	What Cour	ntry?		
	eath v	erai	7916 Underhill Ro	ad 12. Was Decedent	Ever in U.S.	13 Wa	as Decedent of H	2123'		ecify Yes or No		.S.A.	can Indian,		
7050	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heelih and Mental Hygiene. Important: If them 27 is marked other then "netural", or items 23a or 28a-f show eny injury or other treumetic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	?	If Y	es, specify Cub	an, Mexicar	i, Puerto	Rican, etc.)	Bla	Black, White, etc. Specify: White			
2	"netui	leted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Deceder (Give kir	nt's Usual Occup nd of work done ONOT use retire	ation during mos	t of work	ing	16b. Kind of B	usiness/In	dustry		
7	iene. r then the Me	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		mstress				Self	Emplo	yed		
2 2	uld be filed Jental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last, Frank Michalow)					er's Name		, Maiden Suman larski)	16)			
Ma	nd 2 should half hand half hand half treuman		19a. Informant's Name/Relationship (Address (Street				er, City or Town,	State, Zip	Code)		
ָרָ מ	Pages 1 e lent of Her nt: If item ry or othe		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			y, crema	tory or other pla	-	ery .	Date 3-10-05	20c. Location -				
<u> </u>	permit. Depertmit. Importa eny inju		21. Signature Funeral Stylice Lice	see		22. N	Name and Addre	ess of Facilit	y Cva	ach/Rosedale Funeral Home					
J	20.5 2 2		1 (8			<u> </u>					dale, M	D 21	237		
)	Physician /Medical		Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final										Approximate Interval Between Onset and Death		
	Examiner		disease or condition resulting in death)	a	Due to (or as a c	conseque	ence of):	W	174	14/15	(10) (4)	12	2102		
T	ed sit	niner		b. SA	com	7	1E (~1	317	つ				2004		
Ś	e execut ian and unial-tran	i Examiner													
700 4	i certificete be executed inding physician and use es the bunal-transit	n/Medical	that initiated events resulting in death) Last Due to (or as a consequence of): d.												
	death of etter	iciar	Part II. Other significant conditions of	ontributing to death h	out not resulting in	the und	erlying cause giv	ven in Part I		23b. Did	tobacco use co	ntribute to	the cause of death?		
	at the d by the letache	Physicia	ANEMIA	_			on, ng ozooo gn			1□	. /		bably 4 ☐ Unknown		
50.00	To the Hospital or Atending Physicien: The law requires that the death within 24 butus effer death. To the Funeral Director: After this certificate hes been signed by the etter completely filled in by the funeral director, page 2 should be detached for	Completed by									an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion of cause death?		
-	The la	E O								10	Yes 2☑No	1	Yes 2□No		
3	clen: ertifica ector, j	Be	25. Was case referred to medical examiner?	Handital.			-		of Death	(Check only o	one)				
5	Physic rthis c	<u>1</u>	1 Yes 12 No 27. Manner of Death	Hospital: 1 ☐ Inpati		tpatient ime of	OL DON			-	dence 6 □Oth how injury occur		y)		
5	nding ath. r: After	ation	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Ir	njury	28c. Injur Wor M 1 □	rk? ∣Yes 2⊟∣							
	al or Atte s efter des il Directo ed in by th	Certification:	3 Suicide 6 Could not b determined	286. Place of In	jury - At home, fai c. <i>(Specify)</i>	rm, stree	t, factory, office		1	28f. Location (City or Tou	Street and Numb vn, State)	er or Rura	I Route Number,		
	he Hospit in 24 hour the Funera pletely filk	edicai	29a. Certifier 1. Certifying Ph (Check only one) 2 Medical Exar	y siclan : To the best niner: On the basis o and manner st	f examination and	, death o	stigation, in my o	pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) and ma date and place,	inner as si and due to	ated. the cause(s)		
	Tot Tot Com	Σ	29b. Signature and title of certifier	staf of	tom M	W)	29c. Licens	umber 4	525	- B	29d. Date signe	d (Month,	Day, Year)		
	13		30. Name and address of person who	() ARNI	iMO	Туре, Рг	ing 224	Clyn	ESA	a N	ve, Rl	h7~,	MD2 n3		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 20		rar's Signature	bed									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	•		artment of H tificate of l				giene Reg. No.		
	***			ne (First, Middle, La	ast)				-	·	2. Date of Dea	ith 2	1105	3. Time of Death
	Physicia /Medic		JAMES	SA JO	NES						MAR	Day -	200S	- 2/30 AMO
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
								If Under 1 Year		13/A			OWAR	
	Funeral Director		5. Social Security 1	9377	Sex 7. Age 7. Age 7. Age	(In yrs. last birt	rrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day Apr 13,	1918	Coun	lace (State or Foreign try) Sachusetts
	and and		Usual Residence of 10a. State	10b. County		10c. City, Town	or Lo	cation					1	0d. Inside City Limits
	f sho	tor	MD	Howar	ď	Woodst	-ocl	k						1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Nu					10f. Zip Code				10g. Citizen	of What Coun	try?
	death with the Maryland ms 23a or 28a-f show f must be notified at	Funeral Director	2249 Mei	rion Pond				21163	}			Unite	ed Stat	ces
	er dea	nue	11. Marital Status		12. Was Decedent E Armed Forces?		13. V	Was Decedent of H f Yes, specify Cuba	lispanic O an, Mexica	rigin? (Spe an, Puerto l	cify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
50	d be filed within 72 hours after death with the Marylan anal Hygiene and Hygiene with the Tratural', or liems 23a or 28a-f show ked other than Tratural', or liems 23a or 28a-f show to event, the Modical Exam has man than colline and the c	by		ried 2 Married 4 Divorced	1 ZYes 2 N If Yes, Give Year or Dates:	。 L939-46	1	1 ☐ Yes 2 🛣 No	Specify	y:		Spe	ecify: Wh	ite
5	72 hours 'natural', dicul Exa	Completed	/Sna	15. Decedent's E	ducation		Deced	dent's Usual Occup	ation	act of working	20	16b. Kind o	f Business/Ind	
7	within ventering that then received the within the windows of the windows of the within the within the windows of the within the windows of t	nple	Elementary/Sec	, , ,	College (1-4or 5-	+)		kind of work done o DO NOT use retired	d)	IST OF WORKI	ig	_		
7	lled w lygier her th		17 Father's Name	(First, Middle, Las.	e)		Eng	gineer	19 Moti	haria Nama	(First, Middle,		eries	
au	d be f	o Be	James Jo		•/					h Mar		Maidell Suil	name)	
	shoul nd Me mark	ဥ	19a. Informant's N	Vame/Relationship	(Type, Print)	19b.	Mailin	ng Address (Street a				r, City or To	wn, State, Zip	Code)
Ĭ.	and 2 aith a 27 is er trai		Michele	Drury/Gr	anddaughtei	22	249	Merion P	ond	Woods	tock, M	D 211	63	
ole	of He of He of Item		20a. Method of Dis	'	Removal from State	20b. Place of cemeter	Dispo y, cren	sition (Name of matory or other plac	ce)	D	ate	20c. Location	on - City or To	wn, State
Банттоге	nii. Pages 1 and 2 shou extment of Health and M crtant: if Item 27 is mari injury or other traumati		° 4 ☐ Donation	5 Other (Speci	ify)	Metro		ematory		3-8-2			sville	
a D	permit. Page Depertment of Important: If any injury or once.		21. Signature of F	funeral Service Lice	-while	M01044								ily FH Inc. MD 21043
			23a. Part1. Enter	the disease, or cor	nplications that caused y one cause on each lin	the death. Do n								Approximate Interval Between
- 1	hysician	1	Immediate Cause disease or conditi	(Final ion	Resp	irako	n	Garles	re		1. to	0 16	rond	Onset and Death
	/Medical Examiner		resulting in death)	(Due to (or as a	consequence	of):	0,			,	ation		the state of the s
		20	Sequentially list of	onditions,	b. Due to (or as a	consequence	of):	agute		Xa	cerso	alion		day
	uted d ansit	Examiner	Sequentially list c if any, leading to i cause. Enter Und Cause (Disease o that initiated even)	erlying r injury	Acut	- lar	(Da	00-1.	2					dans
ĵ	an an rial-tr	Еха	resulting in death)	Last	Due to (or as a	a consequence of):								or any
09/89	riticate be executed ng physician and as the burial-transit	ledical		•	d							·		U
	E O S	/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy						334	Date of delive	
ô n	w requires that the death cer been signed by the attendir should be detached tor use	Physician/N	in the past 12	2 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)	<u> </u>				Month	Day Year
J.	at the by the tache	hys	9 Unknow	'n	9□ Unknown									
<u>က်</u>	res tha iigned be de		Part II. Other sign	ificant conditions	contributing to death bu		the u	nderlying cause giv	en in Pari	-				e cause of death?
Š	requi	eted	ach 1	th- marco	e my) 10	00	1 In	a co	Mo	-			ably 4 Unknown
Hecord	sician: The law requires that the certificate has been signed by thirector, page 2 should be detache	ompleted by	gash	oin (est rall	L See	Ra	2			24a. Was autop	rmed?	prior to cor death?	osy findings available inpletion of cause of
		e C	25. Was case refe	erred to medical					26. Plac	ce of Death	1 Tes		1 🗆 Yes	20 No
	S (0 T)	To B	examiner? 1 🗆 Yes 🦂	(No	Hospital: 1 Inpatie	nt 2 ER/Ou	tpatien	nt 3 DOA Oth			me 5 ☐ Resid		Other (Specify	')
		ion:	27. Manner of Dea	5 Pending	28a. Date of Injur (Month, Day	y Year) 28b. 1	Time of njury	f 28c. injun War	yat k? Yes 2[2	28d. Describe h			
DIVISION	Attence or death rector: by the	ficat	2 Accident 3 Suicide	investigation 6 Could not determined	he	ıry - At home, fa	rm. str		105 2		28f. Location (S	Street and Nu	umber or Rura	l Route Number,
É	tal or A rs efter al Dire ed in b)	Certification;	4 🗌 Homicide	dotolitillio	building, etc	: (Specify)		eet, factory, office			City or Tou	n, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the fune	edical	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	Physician: To the best of miner: On the basis of and manner sta	examination an	d/or inv	h occurred at the tin vestigation, in my o	pinion, de	ath occurre	ed at the time, o	date and plac	ce, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature an		Free			29c. Licens	e number	1		29d. Date sig	gned (Month,	Day, Year)
	r /)),tCCP				684	5		MAR	. 07	, 2005
-	10		30. Name and add	dress of person who	completed cause of de	eath (Hem 23a)	Type,	Print) MAI.	- C	1+1	NG49	EN	, MI	, FCCP
	Sta	te	31. Date filed (Mo	inth, Day, Year)	32. Registra	ar's Signature	»-C)	, ,	, ~	70 70	<i>†</i>		
	Registr			MAR O	9 2005	-0	4	boards ;						

DHMH 17 Rev 1/2001

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		1	For Stete		State of Ma	aryland /	-	riment of He tificate of D		vientai Hy	gierie Reg. No.		
	Physicia	ın	Registrer 1. Decedent's Name	(First, Middle, Las	" m. 1	DNE	=5			2. Date of De Month		005 3 05	3. Fime of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If AND FC AVV) 5. Social Security Nu 120-42-1	1977 1	lust Cont	a (In yrs. last I	birthday) Yrs.	4b. City, Town, or ANAM If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		A		ath INDEL Inhplace (State or Foreign country) ermany
•	land ow	-	Usual Residence of I 10a. State	10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
	a-fsh iffied	ctor	MD	Anne Aru	ındel	Gamb	rills	,					1 ☐ Yes 2 🗖 No
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Num 881 Cla	_{ber} affy Aver	nue			10f. Zip Code 210	54		•	izen of What C USA	Country?
920	be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel" or items 23a or 28a-f show event, the Modical Examiner must be notified at		11. Marital Status 1 □ Never Marrie 3 □XWidowed 4		12. Was Decedent Armed Forces? 1 ☐ Yes 2XX If Yes, Give Year or Dates:			/as Decedent of His Yes, specify Cubar ☐ Yes ※XXNo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	an 2 32	Completed by	(Special Special 15. Decedent's Ed fy only highest gra idary (0-12)	lucation de completed) College (1-4or		(Give k life. D	ent's Usual Occupa kind of work done d IO NOT use retired)	tion uring most of wor	king		ind of Busines	s/Industry	
121	filed w Hygier Sther ti		17. Father's Name (First, Middle, Last)			Cash	iler	18. Mother's Nan	ne (First, Middle	1		
and	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be		ian Maieı					Elisa	beth Ei	cher		
ary	should nd Men marke umaric	۲	19a. Informant's Na			1	9b. Mailin	g Address (Street a				r Town, State	Zip Code)
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Christ	a A. Morg	gan (Frier				n Street				MD 20737
Baltimore,	Pages 1 and 2 nent of Health nt: If item 27 i		20a. Method of Disp		Removal from State	ceme	itery, crem	sition (Name of atory or other place		Date		ocation - City o	
ţi.	tment tent: tent:	1	° 4 □ Donation	5 ☐ Other (Specify	y)	Metr		matory		7/2005	_	timore	, MD
Bal	permit. Pages 1 Department of H Importent: If ite any injury or ott		21. Signature of Fur	g. Open	_		1	Hardesty 12 Ridge	lv Avenu	e. Anna	poli	s, MD 2	
	Physician /Medical		23a. Part1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	Final	plications that cause one cause on each I	trac	lino	ir the mode of dying	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner				Due to (or as	a consequen	ce of):						
	uted I Insit	Examlner	Sequentially list concause. Enter Under Cause (Disease or ithat initiated events	nditions, mediate rlying injury	b. Due to for as	a cons ∗ueno	ce of):						
68760,	cate be executed physician and the burial-transit	cal Exa	resulting in death) L		Due to (or as	a consequen	ce of):						
.89	tificate ng phys as the	Medical	ic constant						-				
O. Box	To the Hospital or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 25 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)				23d. Date of o Month	lelivery Day Year
rds, P.O	quires that the signed by all be detacted	ed by Ph	Part II. Other significant	Sol (entributing to death	А	ig in the ur	ndertying cause give	en in Part I.	1		use contribute	to the cause of death? Probably Unknown
Division of Vital Records,	The law require ate has been si page 2 should I	Completed by		-		· · · -				24a. Wa auto per 1 \(\text{Yes}	opsy formed?	prior to death	
ital	iclan: Th certificate rector, pag	Bec	25. Was case reference examiner?	red to medical					26. Place of De	ath (Check only	one)		
of V	g Physiclan: er this certific eral director,	2	1 ☐ Yes 2 27. Manner of Death	h	Hospital: 1 Inpat 28a. Date of Inj (Month, D.	ury 28	Outpatien b. Time of Injury		4 🔲 Nursing r	dome 5 ☐ Res 28d. Describe			pecify)
visior	Attending I or death. ector: After by the funer	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigatio 6 Could not be determined	n 28e. Place of Ir				Yes 2 □ No		(Street arown, State		Rural Route Number,
Ö	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	1 Certifying Pt	nvsicien: To the bes	t of my knowle	dge, death	occurred at the tin	ne, date and place	e, and due to the	e cause(s) and manner	as stated.
	n 24 h	Medical	(Check only one)	2 Medical Exe	miner: On the basis and manner s	of examination tated.	and/or inv	vestigation, in my o	pinion, death occi	urred at the time			
	To the To the Comp	M	29b. Signature and	title of certifier)	29c. License	e number		29d. Da	ite/signed (Mo	onth, Day, Year)
	011	0	CA	ADITA	-	OPKA		VS	1028	5	1	5/01	
	U		600	Killer	29	RQ	Su	to 23	31 7	Anna	fol	y M	021401
	St Regist	ate	31. Date filed (Mo	MAR 0°9 2	005 32 legis	trar's Signature	1	× 5			-		

		For State Registrar	State	of Marylan		artment of H rtificate of I			giene	5 078	98
		1. Decedent's Name (First, Middle	a, Last)					2. Date of De		3. Time	of Death
Physici /Medic		Charles	R.	Ki	ng			Month March	Day 200	Year 1500) М
Examin		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, Town, or	Location of De	eath	4c. County		
		Anne Arundel	Medical	Center		Annapo			Anne	Arundel	
Funeral		5. Social Security Number	6. Sex XX M 2□ F	7. Age (In yrs.		If Under 1 Year Months Days		lin. (Month, Da	y, Year)	Birthplace (State Country)	or Foreign
Director		214-34-2860	MAN 201	68	Yrs.			Sept. 2	20,1936	Maryland	
and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside (City Limits
Marylan f show	ŏ	MD Anne	Arundel	Day	vidson	willa				1 ☐ Ye	2) No
288 100	Director	10e. Street and Number	iii diide i	Da	VIUSOII	10f. Zip Code			10g. Citizen of W	Vhat Country?	
3a or		3529 Russell T	homae Ian	Δ.		21035			USA	,	
deeth ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No	14. Race	e - American Indian,	
or ite	교	1 Never Married 2 Marr	ied 1 2 Yes	2 🗆 No	i	If Yes, specify Cuba		Jerto Hican, etc.)		k, White, etc.	
ours .i.a	d by	3 Widowed 4 Divorced	Year or E	ive 1959	-61	1 ☐ Yes ZXNo	Specify:		Specify	White	
be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madral Examinational bandlifted at	Completed	15. Decedent (Specify only highes	's Education at grade completed))	(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kind of Bu	siness/Industry	
hen he	ldm	Elementary/Secondary (0-12)	College ((1-4or 5+)	life.	DO NOT use retired	1)		1	. 1	
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EV IN		23a. Pan 1. Enter the dise ye, or shick, / r heart fillural List	complications that	caused the death						Approxima	te
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/Medical		disease or condition resultin of death)	a. Due to	(or as a conseq	uence of):	Trefor	1 11/5	t-ress	There	me_ /-	q
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ate be executed hysician and the burial-transit		resulting in death) Last	Due to	or as a consequ	uence of):						
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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Dennis James Lanning 12:40p M 2005 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1034 Thomas Road Glen Burnie If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral Days Hours 1 □ M 2 □ F 52 Vrs Director 220-60-9717 Nov 10 1952 MdUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow event, the Medical Examinar must be notified at Md Anne Arundel Glen Burnie 1 ☐ Yes 2/☐ No Funeral Director or itams 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1034 Thomas Road 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 TYes 2 □ No If Yes, Give Year or Dates: 1977 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced 1986 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) State of Maryland auto mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h James Lanning Goldie Henard traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 ie any injury or othar trau once. Margaret Rose Lanning (spouse) 1034 Thomas Rd., Glen Burnie, Md 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 3-10-05 Marriottsville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee > Gaige Haight Serbert P.O. Box 195 Sykesville, Md 21784 Approximate Interval Between Open and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 autopsy performed 212 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 ☐ Suicide Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D22110 mo 7845 Oakward Rd #300 Glen Burnic, Md Ziow/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kapla 31. Date fifed (Month, Day, Year) 2003 Registrar

Marvin Harold Lehr 46. Day, Town, or Location of Death (Accounty of D			1 - For State of Ma		artment of Health and rtificate of Death	Reg.	4000 11/4	00
Social Security Number S. Seek Seek	/Med	ical	Marvin Harold Lehr		4b. City, Town, or Location of Dea	March 4,	, 2005 11:30a	
The part of the			5. Social Security Number 6. Sex 7. Age		If Under 1 Year If Under 24 Hr	. (Month, Day, Ye	9. Birthplace (State or Country)	Foreign
George Lehr Georg	the Maryland 28e-f show	ector	Md Carroll		ter	100	10d. Inside City 1 □ Yes 2	
George Lehr Georg	after death with or Items 23e or	y Funerai Dir	2944 Littlestown Pike 11. Marital Status 1 Never Married 2 Married Press. Given	Ever in U.S. 13.	21158 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	US	14. Race - American Indian, Black, White, etc.	
George Lehr Georg	d within 72 hours glene. r then "natural;		15. Decedent's Education (Specify only highest grade completed)	1953 16a. Deced	A dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking). Kind of Business/Industry	
23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immedical Examiner	hould be filed to Mental Hygunal Hygunarked other metic event,	Be	George Lehr	19b. Mailii	Otillia	Sommers	·	
23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immedical Examiner	ges 1 and 2 s t of Health an If Rem 27 is or other treu		Doris Nelda Lehr (spouse) 20a. Method of Disposition	2944 20b. Place of Dispo	Littlestown Pike patient (Name of matory or other place)	, Westminst	er, Md 21158 Location - City or Town, State	
Shock, or heart failure. List only one cause on each line. Intervals Inte	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility H	aight Funer	al Home & Chapel	
Sequentially list conditions, if air, leading to initialized account of the conditions of the conditio	/Medical		shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) a	LUNG		ac or respiratory arrest,	Approximate Interval Between Onset and De	
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building, etc. (Specify) City or Town, State) City or Town, State) 29a. Certifier (Check only) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ding Phys	٦ ^o	examiner? 1 Yes 2 No Hospital: 1 Inpatie 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	y Year) 28b. Time of Injury	ont 3 DOA Other: 4 Nursing f 28c. Injury at Work? M 1 Yes 2 No	Home 5 sesidence 28d. Jescribe how in 28f. Location (Street	njury occurred and Number or Rural Route Number	er,
and an analysis of the state of	Hospital or / Hospital or / 24 hours after Funeral Dire		4 Homicide building, etc 29a. Certifier (Check only 2 Medical Examiner: On the basis of	of my knowledge, death	h occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.	
and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	To the within 2 To the comple			MD		, ,	Date signed (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. W. COLE ST PENES 900 CATON AVE BALTIMORE MD 216 State Begistrar MAR 0.9 2005	S	tate	E.W. COLE ST AGN 31. Date filed (Month, Day, Year) 32. Registra	IES 900			ORE MD 2120	19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** EWIS MARCH 2005 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 214.38.8222 Usual Residence of Decedent 1 M 2 F Director the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28e-f show other traumatic evant, the Madical Examiner must be notified at AUTI MORE 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code or Itams 23e Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 ☐ Yes 2 12 No Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If itam 27 Is marked other then "netural" or Itan 1 ☐ Yes 2 [2] If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 - Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) DOMESTIC 17 Father's Name (First, Middle, Last, Be 0 19b. Mailing Address /Street and Number or Rural Route Number, City or HUSBAND 20b. Place of Disposition (Name of 20a. Method of Disposition etery, crematory or other 14.05 DWINGS MILLS, MARYLAND 1 Burial 2 Cremation 3 □Removal from State = 5 permit. Page Department of Important: If any injury or once. GARRISON FOKEST 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL HOME 21. Signature of Funeral Service Licensee ROMO PARTIMORE, MARY CANDZIZIZ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLISM **Physician** /Medical Examiner ANCER. STOMACH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be axecuted Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an funeral director, page 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 THomicide 24 hours edical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha 29b. Signature and title of certifier

State Registrar FAHD AMJAD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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s Signature

Marchae

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		1	For State Registrar	State of N	Marylan		rtment of H tificate of t		nd Mental H	lygier Reg. r	- Em U U 1	5 07902
			1. Decedent's Name (First, Middle,	Last)					2. Date of Month		Day Yea	3. Time of Death
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60.	D.		Usual Residence of Decedent									
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C./ 336	urs af	by [3 ☐ Widowed 4 ☐ Pivorced	ed 1 X es 2 [If Yes, Give Year or Date:	s:	1	☐ Yes 21 No	Specify:			Specify: W	hite
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	To the Hospitel or Attending Physician: The law requires that the death certification 24 Hours efter death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		Physician: To the be examiner: On the basis and manner	of examinat							
	ro the	Me	29b. Signature and title of certifier				29c. Licenso	e number		29d. [Date signed (Mor	oth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month MAXIE LUSTER March 06 2005 1015 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-31-1913 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Hours 1□M 215F Days 213-30-4535 91 Yrs. TENNESSEE Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 4 SHIPHORST TERRACE 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 0 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) C. SAM LUSTER RUTHIE (TUNNELL) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY LAKE/DAUGHTER 4 SHIPHORST TERRACE ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD * 4 □Donation 5 □ Other (Specify) OAKLAWN CEMETERY 3-10-2005 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of) Chronic Obstructive Pulmonary Disease Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Cerebrovascular Accident 1 Yes 2 No 3 Probably Myocardia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22No npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

burial-transit the death certificate be executed Division of Vital Records, P.O. Box 68760, physician the as esn for the detached ρ signed b page 2 has certificete or Attending Physicien: ğ this After thi funeral death. Funerel Director: filled in by

Physician

/Medical

Examiner

Director

Completed by Funeral

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item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Evantuer must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than "n any injury or other traumatic assets."

Physician

/Medical

Examiner

with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical Be 10 1 🗌 Yes 27. Manner of Death Certification: Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified

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March 06 2005

21224

4940 Eastern Avenue

Raltimore, Many Lund

Param Decilia MD 31. Date filed (Month, Day, Year)

Johns Hopkins Bayview Medical Center 32 degistrar's Signature

MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

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		1	For State Registrar	State of N	Maryland	•	artment of H tificate of I		Mental Hygi	ene 0 0	5 0	7901	
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Za	od 2 s		Ken Larson	(Son)		106	S. Midfie	ld Road,	Linthicu	ım, MD 2	1090		
ē,	s 1 and 2 if Health item 27 I		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of natory or other place	ce)	Date 2	20c. Location - C	ity or Town, S	State	
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1	151		30. Name and address of person	on who completed cause	of death (Item	23a) (Type:	Print) 7 - Md	1. 14	D. Gola	Isteli	1	9.	
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DHMH 17 Rev 1/2001

ORIGINAL

05-01555 Roy Lechner

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I	Physici /Medic		Decedent's Name (First, Middle, Last) Roy	Edward Lec	chner, Jr.		Date of Death Month March 01	, 2005 Year	3. Time of Dea 1405P.	nth M
	Examir	ner	4a. Facility Name (If not institution, give street and nu Johns Hopkins Bayview Me	edical Center				4c. County of Deat	N/A	
	Funeral Director		5. Social Security Number 279-06-2352 6. Sex 150 M 2 F Usual Residence of Decedent	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hour		Date of Birth (Month, Day, Year March 14		hplace (State or For unitry) iO	'eign
	Maryland -f show	tor	10a. State 10b. County Maryland Baltimo	10c. City, Town or Lo		undalk			10d. Inside City Lin 1 ☐ Yes 2 ☑	
	with the	Director	10e. Street and Number		10f. Zip Code	01000	"	Citizen of What Co	•	
ō	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other then "neturel", or items 23a or 28e-1 show other treumatic event, it e Medical Examirer matter and the additional content of the conten	Funeral	7843 St. Fabian Lane 11. Marital Status 1 Never Married 2 Married 1 Yes, Giff Yes,	2 ☑ No	Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 ☒ No Speci			Jnited St 14. Race - Ame Black, White Specify:	rican Indian,	
0500-CI	In 72 hours n "neturel", Availest Exa	Completed by	3 Widowed 4 Divorced Year or Divorced Specify only highest grade completed)	lates: 16a. Dece	dent's Usual Occupation kind of work done during m DO NOT use retired)		16b.	Kind of Business/	White Industry	
7 7	e filed withln al Hygiene. I other then " vent, It e Me	Com	Elementary/Secondary (0-12) College (pendent			N/A		
yland	ould be fii Mental H arked ott	To Be	17. Father's Name (First, Middle, Last) Roy Edward Lechner, Sr		18. Mo		First, Middle, Maid nise Mari	,		
Mary	2 should be n and Mental is marked or reumatic ever	-	19a. Informant's Name/Relationship (Type, Print)	ather 19b. Maili	ng Address (Street and Nun					
a)	1 and 1 Health tem 27	13	Mr. Roy Edward Lechner		St. Fabian sition (Name of matory or other place)	Lane I	4444	Mary Land Location - City or		
Ē	Pages nent of ont: If it		1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	matory or other place) n Cemetery 3/	9/2005	Ba	altimore,	Maryland	i
Daitim	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other 90ce.		21. Signature of Funeral Service Licensee	I	2. Name and Address of Fai Ouda-Ruck Fun 7922 Wise Ave	neral Ho			nc. 21222	
	Physician /Medical Examiner	ner	resulting in death) Due to Sequentially list conditions b.	cermined (or as a consequence of):	er the mode of dying, such	as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death	
68/60,	eath certificate be executed attending physicien and for use as the burial-transit	edicai Examiner	that initiated events c.	(or as a consequence of):						
O. Box	the death certil y the attending iched for use a	Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year	
ecords, P	w requires that the di been signed by the should be detached	by	Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause given in Pai	irt I.	23e. Did tobacc	_	the cause of death?	
	The lar ate has page 2	Completed					24a. Was an autopsy performed? Yes 2 1	prior to c	topsy findings availa completion of cause 2 \(\subseteq \text{No} \)	able of
on or vital		tion: To Be	27. Manner of Death 28a. Date	Inpatient 2 XER/Outpatier of Injury unk th, Day Year 28b. Time o	nt 3 DOA Other: 4	1k 280		6 ☐Other (Speci jury occurred	unk	
UINISION	To the Hospitei or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide	of Injury - At home, farm, string, etc. (Specify)	eet, factory, office ur	nk 28f	Location (Street City or Town, Sta	and Number or Ru	ral Route Number, U	ink
	he Hospit n 24 hours he Funere pletely fille	edical	29a. Certifier (Check only 2 Medical Examiner: On the band and man							
	To t within To t	×	29b. Signature and title of certifier by CorkeMD	l	29c. License numbe	ər		oate signed (Month rch 02, 2		
			30. Name and address of person who completed caus	e of death (Item 23a) (Type,	Print) 111 Penn S	Street	Baltimo	re, Maryl	and 21201	L
::	Sta Registr		31. Date filed (Marth Day Year) 2005	legistrar's Signature	de la companya dela companya dela companya dela companya dela companya de la companya de la companya de					

DHMH 17 Rev 1/2001

JTF	I LOWEN	STE	EIN 1- For Stata Registrar	State of Ma	aryland / Dep	artment of		-		
			Registrar 1. Decedent's Name (First, Middle, Last))	Ce	rtificate o	t Death	2. Date of Dea	Reg. No U	3. Time of Death
	Physici /Medi		Ruth Lowenstein					Month MARCH	4, 2005	
	Examir	ner	4a. Facility Name (If not institution, give : 1240 FRAILEY WAY	street and number)		4b. City, Town BALTI	, or Location of Death MORE CITY	1	4c. County of I	Death
	Funeral Director		5. Social Security Number 6. Security Number 216-14-4198	X 7. Age	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Day		8. Date of Birth (Month, Day Sept. 2		Birthplace (State or Foreign Country) laryland
	aryland show	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	the Mi	recto	MD N/A		Baltimo	re			10g. Citizen of Wha	1 X Yes 2 □ No
	23a or	ai Di	1240 Frailey Way	у		7 G. 2.p GGG	21205		U.S.A	
036	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "naturel", or Items 23a or 28e-f show event. The Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 N	f Hispanic Origin? (Sp uban, Mexican, Puerto o Specify:	pecify Yes or No- Pican, etc.)	14. Race - / Black, V Specify:	American Indian, Vhite, etc. White
Maryland 21215-0036	natur	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece (Give	dent's Usual Occ	upation le during most of work red)	king	16b. Kind of Busine	ess/Industry
212	d within giene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	T)	mstress	red)		Manufact	curing Comp.
pui	ild be filed lental Hygie ked other ic event.	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	a. Ing comp.
ıryla	should be ind Menta marked umetic ev	٦	Harry Lowenstein 19a. Informant's Name/Relationship (Ty)	rpe, Print)	19b. Maili	ng Address (Stree	Gertre et and Number or Rui		enblum	to Tin Codol
, Na	and 2 saith ar		Mr. Robert Ebersol		2319	Cool Wo	ods Court	Jarrett	sville, M	aryland 21084
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumetic ance.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	20b. Place of Dispo				20c. Location - City	
altin	nit. Pa vartmer ortent injury e.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	⇒ Heather	Meadowri	uge ceme Name and Add	• ,		. Ruck, I	Maryland
ä	Depa Impo any ii		Heali	en (ex	ان 5	305 Harf	ord Road I	Baltimor	e, Maryla	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (Fras a	9.	- W	enotic Cura		\	Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the buriat-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
P.O. Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown	3c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	delivery Day Year
	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause g	even in Part I.			e to the cause of death? Probably 4 [Ponknown
Vital Records,	The ate h page	e Completed	25. Was case referred to medical						prior death	autopsy findings available to completion of cause of ? es 2 \[\text{No} \]
Division of Vi	ding Ph h. After th funeral	ToB	examiner?	ospital: 1	t 2 ER/Outpatien 28b. Time of Injury	28c. Inju	26. Place of Death ther: 4 \(\) Nursing Ho ury at ork? \(\) Yes 2 \(\) No	me 5 Reside		pecify) AT SCENE
Divis	n life	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemin	sicien: To the best of her: On the basis of e and manner state	examination and/or inv	occurred at the trestigation, in my	ime, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
ı.	To th within To th comp	Me	29b. Signature and title of certifier	/		29c. Licen	se number	29	Od. Date signed (Mo	
j	10		Yangk Touch	U/MD	oth (learn 00-) (T	2-i-4)	OCME		MARCH 4	, 2007
_	Ψ		30. Name and address of person who con Emela E, Southa	W. MD		111	Penn Stree	et Balt	imore. Ma	ryland 21201
***	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2005	32. Registrar	's Signature	No.			, - 20	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Maryland / De	ertificate of I			ene 1. No.20	05	07907
1.	Physici ' /Medic		1. Decedent's Name (First, Middle, Lest) Harry R. McKenny			2. Date of Death Month February	Day 23,	^{Year} 2005	3. Time of Death 3:00 PM
	Examir		4a Facility Name (If not institution, give street and number) Future Care Chesapeake	4	4b. City, Town, or Local Arnold	ation of Death	4c. County		nde1
	Funeral Director		5. Social Security Number $181-12-5526$ 6. Sex $1 \times 10^{-1} \times 10^$	Months Davs	Hours Min.	B. Date of Birth (Month, Day, Y	1921	9. Birthpla Penns	ace (State or Foreign y) y lvania
	iryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				100	d. Inside City Limits
	188-1 s	eto.		on Townshi	ip				1 ☐ Yes 2 No
	ath with the Marylan 123a or 28a-f show	吉	107 Man Just 1 - Account	10f. Zip Code 15009		1 7 7	Citizen of W		•
	eath res 23	eral	197 Woodridge Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 1		lispanic Origin? (Spec		ited S	American	
21215-0020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Yes, Give Year or Dates: WWII	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		can, etc.)		k, White, et	
5-0	72 h	etec	15. Decedent's Education 16a. De (Specify only highest grede completed) (Gi	cedent's Usual Occupa ve kind of work done of b. DO NOT use retired	ation during most of working	16	b. Kind of Bus	siness/Indu	stry
121	within ane. than	Completed by	Elementary/Secondary (U-12) College (L-4or 5+)	o. DO NOT use retired ctrical Par			nufact	uring	•
d 2	filled Hygid Sther	20	17. Father's Name (First, Middle, Last)	tirear rai	18. Mother's Name (•
Maryland	uld be Mental rked o	To Be	Mark J. McKenny		Berna	Perkin		,	
lan	2 sho and h is ma			ailing Address (Street a				State, Zip C	ode)
	l and lealth m 27 her tr		Darlene Roosa , Daughter 5 01	d Stonebri	idge Road,				
Baltimore,	ages If ite		Debuilar 2 Defendation 3 Diremoval from State	position (Name of rematory or other place		00 /05	c. Location - (
Ħ	artme ortani Injury	-	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sexice, Licensee	Cemetery 22. Name and Addres		De			sylvania
Ba	Depar Impo		VILLO NS. Haman MO1113	333 Third	Street, Be		ennsyl		15009
			23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	inter the mode of dying	g, such as cardiac or i	respiratory arrest	1	lr C	Approximate nterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition a. Cerebro va.	coule	000	1	<u>/</u>		moot and boats
	Examiner		disease or condition resulting in death) a. Urlbrcva. Due to (or as a cons		ull	dent		- 1	
	sit ad	luer	, h					1	
	tificate be executed g physician end es the buriel-trensit	xar	Sequentially list conditions, if any, leading to immediate	equence of).				1	
68760,	sician sician bunie	calE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consider to the constant of	anuana of):					
.89 x	ertificat ling phy e es th	Physician/Medical Examiner	Due to (or as a consideration of the consideration	squence oi):				1	
Вох	es that the death cert igned by the attendin be deteched for use	lan/	0.			17-14-14			
P.O.	the de	hysi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.				he cause of death?
	s that gned b	by P				1 L Yes	ZLI NO	3 ☐ Probat	bly 4 pronknown
Vital Records,	s been s s been s s should	Completed				24a. Was an a performed	utopsy d?	availa	autopsy findings able prior to bletion of cause ath?
<u> </u>		5				1 ☐ Yes	211110	1 □ Y	res 2□No
Vita	i clan : The certificete rector, peg	Be	25. Was case referred to medical examiner?		26. Place of Death (Check only one)			
of		2	1		4 Mursing Home			* * * * * * * * * * * * * * * * * * * *	
O	ding in. After		27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Dey Year) 28a. Date of Injury (Month, Dey Year) Injury	Work	Yes 2 No	d. Describe how i	injury occurre	1	
Division	Attending Physician: ar deeth. ector: After this certific by the funeral director,	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, s			. Location (Stree		or Rural R	loute Number,
Ö	Ital or irs afte el Dir led in	Ser	4 Homicide building, etc. (Specify)			City or Town, S	tate)		
	To the Hospital or Attending Physwithin 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral d	edical	29a. Certifier (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Ch	th occurred at the time nvestigation, in my op	e, date and place, and pinion, death occurred	due to the cause at the time, date	e(s) and mani and place, an	ner as stete d due to th	e cause(s)
	To th Within To the comp		29b. Signature and title of certifier	29c. License	number	29d.	Date signed	(Month, Da	y, Year)
	1 ~		N V V V V V V V V V V V V V V V V V V V	10 05	50725	Ó	2-2	4-6	2005
	MI		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	0725 uy M.U	2001/1	· N	1	21141
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ETCANSIIC	9 1114	ryville	/ / //	0	NITO
	Registra		MAR 0 9 2005	1. 4					

DHMH 16 Rav 6/95

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Mitchell 4:20A M Clo 2005 /Medical 03 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Manner Health If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 218-46-7594 1 2 M 2 □ F 55 Director Yrs MD 12.10. Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits ral', or items 23a or 28a-f show Examinar musi be notified at MD Baltimore 1 XOVes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2839 21216 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked othar than "natural", or Iter ary or other traumatic avent, the Medical Examination. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fitter 10th grade A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanton Richard Mitchel vancis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE Department of Health a Important: If itam 27 is any injury or other traigns. Chemta L Mitchell Clitton trenue Baltimore MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ling Pank Kandall Stown, MD * 4 ☐ Donation 5 ☐ Other (Specify) 03.11.05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn. Greene Filhe 5151 Paitimore National Fuheral Services an Pike Balto., MD 21229 Ditt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC **Physician** CARDIOUASCULAR DISTASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner transit To tha Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the burial-Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? jo Month Year 4 Pregnant at time of death Day 5 Other (specify) P.0. detached the 9 Unknown 9 Unknown à Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Pe 1 Yes 2 No 3 Probably 4 Onknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes No 2010 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funaral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE CEASAS STREET NORTH EUTAW 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 9 2005 Registrar

DHMH 17 Rev 1/2001

20a. Meyhod of Disposition 11 Disposition 12 Disposition 12 Disposition 12 Disposition 13 Disposition 14 Disposition 15 Disposition 16 Disposition 16 Disposition 16 Disposition 17 Disposition 18 Disposition 18 Disposition 19 Disposition 19 Disposition 10 Disposition 10 Disposition 11 Disposition 12 Disposition 12 Disposition 12 Disposition 13 Disposition 14 Disposition 14 Disposition 15 Disposition 16 Disposition 16 Disposition 16 Disposition 17 Disposition 18 Disposition 19 Disposition 19 Disposition 10 Disposition 10 Disposition 10 Disposition 11 Disposition 11 Disposition 12 Disposition 12 Disposition 12 Disposition 13 Disposition 14 Disposition 14 Disposition 15 Disposition 16 Disposition 16 Disposition 16 Disposition 17 Disposition 18 Disposition 19 Disposition 19 Disposition 10 Disposition 11 Disposition 11 Disposition 11 Disposition 11 Disposition 12 Disposition 12 Disposition 12 Disposition 13 Disposition 14 Disposition 15 Disposition 16 Disposition 16 Disposition 16 Disposition 16 Disposition 16 Disposition 17 Disposition 18 Disposition 19 Disposition 19 Disposition 19 Disposition 10 Dispos
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To a. State 10b. County 10c. City, Town or Location 10d. Inside City 10d. Inside
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23d. Date of delivery Comparison of the past 12 months? Compa
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Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 200
So to the control of the cause of the control of the cause of the caus
25. Was case referred to medical examiner?
2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Numb City or Town, State) 28g. Certifier 19 Certifying Physician: To be best of my Knowledge death assumed to the sum of the s
2 Accident 3 Suicide 4 Homicide 5 Place of Injury - At home, farm, street, factory, office 2 Set. Location (Street and Number or Rural Route Number of Rur
Check only one) Check only one) Check one) Check only one) Check only one) Check one) Check only one) Check one) Check one) Check one) Check one) Check
Read from medical Attending Physician Maryland D41593 march 5, 2005
30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Parts of Slague MV 2333 N. College Staged #652 Rolls as Doc 10.
State Registrar MAR 0 9 2005 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day tonnie Khendon 10 12005 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CELHEL Medical If Under 1 Year | If Under 24 Hrs 8. Date of Birth Month, Day, 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🕶 F Min. 42-20-710C Usual Residence of Decedent Months Days Hours Director Yrs. death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits item 27 is marked other than "naturel", or iteme 23a or 28a-f show other traumatic event, the Medical Exerciting manalizer collined at Completed by Funeral Director 1 No 2 No 10e. Street and Number 10g. Citizen of What Country? 1865 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer onent of Health and Mentat Hygiene. Sont: If Item 27 Ie marked other than "naturel", or ites 1 Never Married 2 Married Yes 2 No Yes, Give ear or Dates: 1 ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉o Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. IDO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (0-12) Colfege (1-4or 5+) Sel Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Mailing Address (Street and Number or Rural Route Number, Cit 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) ŏ 3 Removal from State permit. Page Department of Importent: If any injury or once. 21. Signature of Funeral Service Licensee vias PA w 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart faifure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis

Due to (or as a consequence of): Hours /Medical Examiner Myocardial Infarction b. Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hows by Physician/Medical Examiner Due to (or as a consequence of Hospitel or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 □Unknown Be Completed Gastraintestinal 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Polylythemia 25. Was case referred to medical 1 🗆 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural fnjury 5 Pending death. investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

MD PO

4940 Eastern Axe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 0 9 2005^{22. Red tran's Signature}

Copta,

31. Date filed (Month, Day, Year)

Res

Battimore, MD

March 01, 2005

			1 - For State of Mar		artment of ertificate of	Health and M Death	, ,	iene	0.7011
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last) Howard Thomas Mitchell, Jr 4a. Facility Name (If not institution, give street and number) 918 Pine Road	£.	4b. City, Town,	or Location of Death	2. Date of Death Month March 6	Day Year	
	Funeral Director			75 Yrs.		r If Under 24 Hrs.	8. Date of Birth (Month, Day, May 27,	Year) 9. Birti	hplace (State or Foreign untry) Yland
	72 hours after death with the Maryland natural; or Itame 23a or 28e-f show digal Evaluate molified at	Director	Maryland Harford 10e. Street and Number 918 Pine Road	10c. City, Town or L Joppi	a 10f. Zip Code	1085	10	og. Citizen of What Co USA	10d. Inside City Limits 1 ☐ Yes 2 ☑No untry?
036	urs after death v al', or Itams 23a	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
9500-612121	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or Itams 23a or 28a-f show event, the Medical Evaluar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	edent's Usual Occ e kind of work don DO NOT use retii hographe	e during most of work ed) Y	ing	6b. Kind of Business/	
Maryland	2 should and Mer Is marke aumatic	To Be	17. Father's Name (First, Middle, Last) Howard Thomas Mitchell, Sr. 19a. Informant's Name/Relationship (Type, Print) Bernadine E. Mitchell/Wife	19b. Mail	ing Address (Stree	Bessie J at and Number or Rund, Joppa,	ane McMi	llan City or Town, State, 2	ïp Code)
a)	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti gnce.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disp cometery, cre Harford	osition (Name of matory or other pl	ace) dens 3-9-	Date 2	oc. Location - City or berdeen, M	
pai	permit Depar Impor any in		21. Sign fure of Funeral Serving Licensee 23a. Part1. Enter the disease, or complications that caused it shock, or head failure. List only one cause on each line.	ne death. Do not en	1317 Cok	ress of Facility Funeral Ho esbury Roa ring, such as cardiac	d, Abing	don, MD 21	.009 Approximate Interval Between
,007	/Medical Examiner hysician and physician and the prival-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events C.	consequence of):	ar Acc	cident			Onset and Death I hree weeks
O. BOX 68/	death certifi e attending id for use as	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknow	Fetal death 3	□Ectopic pregnan □ Other (s <i>pecify</i>)	су		23d. Date of delined Month	very Day Year
cords, P.	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contributing to death but Coronary Artery Di	10010	underlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	
n L	The law ate has b page 2 st	e Completed	Atrial Fibrillahon			26. Place of Death		ed? prior to c death? No 1 ☐ Yes	topsy findings available ompletion of cause of 2 No
V 10 1101	두 두 등	ation; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Dath 1 Natural 5 Pending (Month, Day Y	28b. Time o	of 28c. Inju	ther: 4 Nursing Houry at ork?	me 5 Pesider 28d. Describe hov	nce 6 Other (Spec w injury occurred	ify)
DIVISION	To the Hospital or Attending Ph within 24 hours atten death. To the Funeral Director: After th completely filled in by the funeral	Il Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc.	(Specify)		Ŋ	City or Town,		
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of evand manner state 29b. Signature and title of certifier	kamination and/or in	29c. Licer	opinion, death occurr	ed at the time, dat	te and place, and due d. Date signed (Month	to the cause(s)
	10		30. Name and address of person who completed cause of dea	C/ 1-	Print)	3642	m1) 2	March 8,	2005
7	Sta Registr			Signature	henve	581171	<i>rnn</i> 2	1019	

		1- State RegistrarAMEND ITEM #						Mental Hygie	2005	07912
Physici		Decedent's Name (First, Middle, Last)		chae1				2. Date of Death MARCH	Day Year	- 1 9 1 5
/Medic Examir		4a. Facility Name (If not institution, give		. cnael	5	4b. City, Town, o	or Location of De	ath	4c. County of De	
		North Arundel	Hospita	4		Glen	Burnie		Anne F	trundel
Funeral		5. Social Security Number 6. Security Number 15	7. Age M 2□F	(In yrs. last	,,	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	s. 8. Date of Birth		irthplace (State or Foreign Country)
Director		354-24-2641 Usual Residence of Decedent		88	Yrs.			Feb. 21,		orth Dakota
yland		10a. State 10b. County		10c. City, T	own or Lo	ocation				10d. Inside City Limits
a-fer	ctor	Maryland Anne Aru	nde1		Ode	nton				M∑Yes 2 ☐ No
or 28	Director	10e. Street and Number			040	10f. Zip Code		10g.	Citizen of What C	ountry?
ath w 238	ral	516 Gladhill Road				211	13		United S	States
er de	Funeral	11. Marital Status	12. Was Decedent E Amed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Wh	
be filed within 72 hours after death with the Maryland Hygiene. In Hygiene. In a Madical Examiner must be notified at event, the Madical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 ☐ No If Yes, Give Year or Dates:	0		1 ☐ Yes 2X No	Specify:		Specify:	T77 * .
2 hou		15. Decedent's Edu	cation	1-1-	6a. Dece	dent's Usual Occup	pation	166	. Kind of Business	White s/Industry
thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+	-)	(Give	kind of work done DO NOT use retire	during most of w d)	orking		,
ed wi	Con		5+			Officer			Militan	:у
be fill hall H hd oth	Be	17. Father's Name (First, Middle, Last)		_			18. Mother's Na	ame (First, Middle, Maid		
2 should and Men le marke aumatic	ပို	Herman John	Michae			- University	Louis		Baumgart	
d 2 s th an th an traur		19a. Informant's Name/Relationship (Ty Rita Mary Michael	*			g Address (Street Gladhill		Ru <i>ral R</i> oute Number, Ci denton, Mai		
tem 27		20a. Method of Disposition		20b. Place	of Disno	sition (Mama of	1		Location - City of	
permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If item 27 le marked tother than any injury or other traumatic event, the Mance.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ceme	etery, crer	ns Cemete				
permit. f Departm Importar any inju		21. Sign to e of Funeral Service Licens	90	TID VC	22	Name and Addre	ss of Facility			e, Maryland
Depariment Department		Quanta RUS	mar	M0095	7 12	naldson l II Annapo	Funeral Slis Roa	Home & Crend Odenton	natory I Marylar	id ^A 21113
		23a. Pant. Enter the disease, or complishock, or heart failure. List only or	cations that caused t	he death. C						Approximate Interval Between
Physician) H	Immediate Cause (Final disease or condition	Priture							Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a		ce of):					
£.	<u>l.</u>	Sequentially list conditions,	Due to (or as a	200500U00	of					
ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause Issue of jury that initiated events	Due to (or as a	consequent	ce or):					
ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequenc	ce of):					
ysicia ysicia	edicai									
i≡ onĕ		IS SERVALE.								
The law requires that the death certaine has been signed by the attending bage 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2	f pregnancy	ath 3	Ectopic pregnancy			23d. Date of de	,
the all	/sici	1 Yes 2 No	4☐ Pregnant at ti 9☐ Unknown	me of death		Other (specify)			Month	Day Year
that the		Part II. Other significant conditions con	tributing to death but	not resulting	n in the ur	adorhioa causo an	on in Part I	23a Did tobacc	O uso contributo t	o the cause of death?
signe d be	d by	•		THOU TOO BIGHT	9 111 010 01	idenying cause giv	on in raiti.	1 ☐ Yes		robably 4 Unknown
w requir been si should	ompieted							24a. Was an		
The larate has page 2	duc							autopsy performed	prior to	utopsy findings available completion of cause of
	e C	25. Was case referred to medical					26 Place of Do	1 ☐ Yes 2 ☑ ath Check on one)	No 1 ☐ Yes	2 □ No
di is	0 0	examiner? 1 ☐ Yes 2 ☑ No	ospital: Inpatient	2 ER/	Outpatien	t 3 DOA Oth		Home 5 Residence	6 Other (Spe	icifu)
Attending Physician: r death. ector: After this certific. by the funeral director.	T:uc	27. Manner of Death	28a. Date of Injury (Month, Day	(- W - W - W - W - W - W - W - W - W -	. Time of Injury	28c. Injun Worl	/ at	28d. Describe how in		J. J. J. J. J. J. J. J. J. J. J. J. J. J
tendii eath. or: Ai	catic	2 Accident investigation					Yes 2 □ No			
or Atl ifter d Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, <i>(Specify)</i>	farm, stre	eet, factory, office		28f. Location (Street City or Town, St.	and Number or Reate)	ıral Route Number,
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Processing Physics	isians To the best of	mu kaaudad	laa daash					
24 hc 24 hc etely	Medical	(Check only 2 Medical Examin	er: On the basis of e and manner state	examination :	ige, ceath and/or inv	estigation, in my o	ne, date and plac pinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
Fo the within Fo the complex	Me	29b. Signature and title of certifier				29c. License	number	29d. I	Date signed (Mont	h, Day, Year)
1		Dougla lease	ehun	n	٠, ٨	1 000	TTCI	3 E. I		7006
15	1	30. Name and address of person who co			-	Print)	3 1 9 7	7 10	11000	7,2005 NO 20904
\		ZHILL SIECE	11500	SUIN	erla	nd HI	ic wa	4 Silver	spring	ND 20904
Sta		31. Date filed (Month, Day, Year) MAR 0 9 2005	32. Registrar	s Signatur	and!					
Registra	ar	MAIN O COOL	ME STERMENT FOR	17		105				

			1 - State	State of Marylan		artment of F		, ,	/	2005	07913
			1. Decedent's Name (First, Middle, Last)	h 4 1		imodic or	Dealit	2. Date of Dea			3. Time of Death
	Physici /Medic		Kobert	MCIV	er			Month OS	Day	5 <u>05</u>	37pm
	Examin	er	4a. Facility Name (If not institution, give s		. he was	4b. City, Pown, o	r Location of Deat	h d n m n i	40.0	County of Death	01750
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		147303667	M 2□F 8	5 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 2/08	192	Coun	try)
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or La	cation				11	Od. Inside City Limits
	Many Fight	ţō	MD NA	Bal	timor	ce :					X□XYes 2□No
	death with the Maryland ms 23a or 28a-f show rmust be rodiffed at	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citiz	en of What Coun	try?
	s 23a	rai	3103 Leighton A		2 1.2	212			T-	U.S.A.	
	fler de rittem	Funerai	11. Marital Status X X X X X X X X X X X X X	 Was Decedent Ever in U. Armed Forces? X∑Yes 2 ☐ No 			lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Ι,	4. Race - America Black, White, e	
2-003p	72 hours after neturel', or ite dical Examine	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 No	Specify:			Specify: B1	ack
<u>ہ</u>	"netu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kin	d of Business/Ind	lustry
7	e filed within al Hygiene. other than vent, I've We	фшо	Elementary/Secondary (0-12) 8th grade	College (1-4or 5+) na	<i>1110.</i> 1	Cook	u)		Re	estaura	nt
and	be filed within 72 hours after death with the Marylan Hygiene. d other than "neture!, or liems 23a or 28a-f show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,			
	2 should be and Mental is marked of eumetic eve	2	Joseph Edward M					e Worth			
=	s t and 2 should f Health and Mer item 27 is marke other treumetic		19a. Informant's Name/Relationship (Type Effie Hall-Sist	•	h.c.			Baltim			Code) 1215
e,	s t and of Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	1			ation - City or To	
Ē	Pages nent of int: If it iry or o		t □ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	amoval from State				3/11/05	Ow	ings M	ills, Md
Salti	permit. Pages 1 Department of H Importent: If ite eny injury or ott		21. Sign ttu e of Funeral Service License			Name and Addre		The state of			
u	<u>v</u> ∪ = 9		220 Board Street Williams of annual	rations that sourced the death	4	1300 Wak	oash Ave	e, Balt		re, Md	21215 Approximate
١,			23a. Part . Enter the tisease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	n. Do not on	TWO H	o A				Interval Between Onset and Death
-	nysician /Medical		disease or condition resulting in death)	Due to (or as a constant	vence of):	0116	2000	tarlur			
	Examiner		Sequentially list conditions	De ist	Mera	I Vai	3 Cala	Y Or	360	Y'E	
1	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
· ·	execut n and ial-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):						
04/8	death certificate be executed e attending physician and id for use as the burial-fransit	dicai		,							
ء ح	ertifica ding pt	a a	IF FEMALE:	20 Kuga autaama af aranga					-		
POX	death certific a attending p d for use as t	Physician/M	in the past 12 months?	3c. If yes, outcome of pregnate 1□Live birth 2□Fetal 4□Pregnant at time of de	Ideath 3	Ectopic pregnancy Other (specify)	1		2:	3d. Date of delive Month	ry Day Year
9	the y th	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
'n	The law requires that the death sie has been signed by the atter page 2 should be detached for	by P	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.				e cause of death?
cords,	w requir been si should I	eted							es 2□		
Lec Lec	2 2 3	ompieted						24a. Was a autops	V.	death?	psy findings available inpletion of cause of
vital	Physicien: The law this certificate has t ral director, page 2 s	e Co	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2IX No	1 🗆 Yes	2☑ No
2	nysicionis cer direct	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Dth	ac .	lome 5 Reside		Other (Specify)
0 0	ing Pt	ë.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	ow injury	occurred	
Division	death ctor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	nme farm str		Yes 2 □ No	28f. Location (Si	treet and	Number or Rural	Route Number
2	el or A s after Il Dire	Certificat	4 Homicide determined	building, etc. (Specify	y)	coi, lactory, office		City or Town			
	To the Hospitel or Attending Physicien: within 24 hours after death to the Funeral Director: After this certifica completely filled in by the funeral director, I	edicai (29a. Certifier 1 (Check only 2 Medical Examir	ician: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the tir	me, date and place	e, and due to the carred at the time. d	ause(s) a	and manner as sta	ated. the cause(s)
	thin 2,	Med	29b. Signature and title of certifier	and manner stated.	1/2 /	29c. Licens	e number	2	9d. Date	signed (Month, L	Dav. Year)
	8 11 11 1) Whi	Attendin	RIN	Stain	D536	542	Mar	ich 7	2005
	111		30. Name and address of person who co	npleted cause of death (Item	1 23a) (Type,	Print)	10 -) > D	01	W D	2005
	1+1		X/DO LHOU	5601 LOC		1 V9V1 13	IVEF 3	O) Pa	ckt.	Mono	2(2)
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 200	32 Registrar's Signat	A A	we					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artmen <i>rtificat</i>			nd Me	-	giene	OOE	07011		
	Physic	ian	Decedent's Name (First, Middle, Last	•					-	2. Date of De			3. Time of Death		
	/Medi			ice Medley						March	3, 2	2005 Year	9:50P M		
4	Exami	ner	4a. Facility Name (If not institution, give			4b. City,	Town, or L					County of Dea			
	Funeral		Southern Maryla 5. Social Security Number 6. S		s. last birthday)	If Under	1 Year	linto		R. Date of Bir		ince Ge			
1	Director		577 58 4683	□MXXF 62	Yrs.	Months	Days	Hours	Min.	B. Date of Bir (Month, Da Jan 31			thplace <i>(State or Foreign</i> bun <i>try)</i> St Virginia		
	pug *		Usual Residence of Decedent 10a. State 10b. County	100.6	City, Town or Lo						,	75 1102			
	Maryle f sho	ō	Maryland Prince G										10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	28a	rect	10e. Street and Number	leoi ge S	F	ort Wa		gton			10g Citi	zen of What Co	X		
	h with	a D	1305 Split	Rock Lane				20744				United			
	arms a	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced				ify Yes or No		14. Race - Ame	nican Indian,		
36	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Examir without be invitible at	Y.F.	1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	1 ∐ Yes XXX No If Yes, Give		1 Yes 2		Specify:	rueito ni	can, etc.)		Black, Whit			
21215-0036	tural	Completed by	15. Decedent's Ed	Year or Dates:		dent's Usua	****	ion					oAmerican		
215	within 72 ene. then "na ha Medi	plet	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of wor DO NOT us	rk done du		of working	1	160. KII	nd of Business/	industry		
	od wit	Som	Elementary/Secondary (0-12)	College (1-401 3+)	Mai	1 Sor	ter					Posta	1Service		
Maryland	ba file ital H) id oth event	Be	17. Father's Name (First, Middle, Last)				1	8. Mother!	s Name (First, Middle,	Maiden				
ryla	hould d Mer marka maric	L _O	Oatis Cho 19a. Informant's Name/Relationship (7		T					Leman					
Z	permit. Pages 1 and 2 should ba filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Itams 23s or 28s-1 show any injury or other traumatic event, the Medical Exact instruct be notified at Once.		Michael T. Medle	y (son)	196. Mailir	ng Address 5 Sp1	(Street and	dNumber ock I.a	or Rural I ane	Fort I	ar, City or Mach	Town, State, Z	Zip Code) MD 20744		
ē,	s 1 ar if Hea item 3		20a. Method of Disposition	20b.	Place of Dispo cemetery, crer	sition (Nam	ne of	M 1	Dat	000		cation - City or			
E O	Pages nent of the ant: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemerery, crer Lincoln	Memo	mer piace) rial	March	h 10,	2005					
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service Licen	Lincoln Memorial Cemetery Suiltand, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandira Ferry Road, Clinton, Maryland 20735											
	207 2 2		Jouis A. Bran		A	Lexan	dira	Ferry	y Roa	ıd, C1i	intor	ı, Mary	land 20735		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea one cause on each line.	ith. Do not ent	er the mode	e of dying,	such as ca	ardiac or r	espiratory ar	rest,		Approximate Interval Between		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Sepsis									Onset and Death		
	Examiner		ſ	Due to (or as a conse	quence of):										
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse											
W	icuted nd iransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Stage IV	Deco	bitus	Vic	er							
90,	cate ba exacuted physician and the burial-transit	I Ex	resulting in death) Last												
8760,	g th	dicai	•	d. Paraples	ria										
Box (death cartifi e attending I id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy						2	3d. Date of deli			
	0 0	iclai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	aldeath 3 □	Ectopic pre Other (spe					2.	Month	Day Year		
P.0	at the de by the a stached	hys	9 🗆 Unknown	9□ Unknown											
<u>'ò</u>	The law requires that the title has been signed by the rage 2 should be detached.	by	Part II. Other significant conditions co	ontributing to death but not re-	sulting in the ur	nderlying ca	iuse given i	in Part I.					the cause of death?		
orc	w requir been si should I	eted							-	1 🗆 Y	es 2]No 3□Pro	bably XXUnknown		
of Vital Records,	has b	ompleted								24a. Was a autops perfor	sy	prior to c	opsy findings available ompletion of cause of		
E		e Co	25. Was case referred to medical							1 ☐ Yes	2 💢 No	death? 1 ☐ Yes	2 🗆 No		
>	d is	0 8	examiner?	Hospital:] ER/Outpatien	1 3 DO	Other			Check only or		□Other (Spec			
0	ding Phys h. After this funeral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of		Ic. Injury at Work?			I. Describe h			(יויי)		
Siol	Attending ir death. ector: After by the funer	catic	2 ☐ Accident investigation		Injury	М		s 2□No							
-	after death after death Director: d in by the	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	eet, factory,	office		28f	Location (Si City or Town	treet and n, State)	Number or Ru	al Route Number,		
	Hospital (24 hours at Funeral Distely filled i	O	29a. Certifier 1 Certifying Phy	reician. To the host of my ke	outodes death										
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exam	/sician: To the best of my known iner: On the basis of examination and manner stated.	ation and/or inv	estigation, i	it the time, in my opini	date and p ion, death	occurred	I due to the catthe time, d	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c.	License nu	umber		2	9d. Date	signed (Month,	Day, Year)		
}			H. ARCI	. 670		D	006	1216	7		316	+105			
	9		30. Name and address of person who c			Print)			*			•			
			Akhondi Hossein A.MT 31. Date filed (Month, Day, Year)). Douthern Mary 1	and Huspin	W.750	35ur	ratts	Road.	Clinto	n 14	0.20739	Ś		
	Sta Registra			32. Redistrar's Signa	A P	falle									

			For State Registrar	State of Mar		artment of Health and rtificate of Death	Re	g. No. 2005	0791		
	Physicia /Medic		Decedent's Name (First, Middle, Last) JAMES			MOORE	2. Date of Death Month MARCH	OS 2009	1,-		
	Examin		4a. Fecility Name (If not institution, give str SHNS HOPKING 5. Social Security Number 6. Sex	MOSPITAL	(In yrs. last birthday	4b. City, Town, or Location of D RALTIMORE If Under 1 Year If Under 24 I		4c. County of Deat	th thplace (State or Foreign		
	Funeral Director			A 2□F	57 Yrs.		AUG. 1,	1957 MARY	TLAND		
	death with the Maryland ims 23e or 28a-f ehow r must be notified at	Director	10a. State 10b. County N/A		10c. City, Town or L		10	0g. Citizen of What Co	10d. Inside City Limits 11 Yes 2 □ No		
	23e or 2		10e. Street and Number 1827 E. BIDDLE STREI			10f. Zip Code 21213		U.S	S.A.		
920	n 72 hours after death with the Marylan "naturel", or Items 23e or 28a-f show wiked Examine must be molified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	I .	Was Decedent of Hispanic Origin's If Yes, specify Cuban, Mexican, Proceedings of the Procedings of the Procedings of the Procedings of the Procedings of the Proceedings of the Proceedings of the Procedings of the Procedings of the Procedings of the Procedings of the Procedings of the Procedings of the Proceedings of the Procedings of the Procedings of the Procedings of t	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify: BL			
21215-0036	within 72 ho ene. then "natur its Medical	Completed	15. Decedent's Educa (Specify only highest grade of 12th		(Giv	edent's Usual Dccupation e kind of work done during most of DO NOT use retired) ER	working	16b. Kind of Business/			
	be filed ntal Hygi od other event, t	a	17. Father's Name (First, Middle, Last) WILBERT THOMPSON			18. Mother's ANNA MC	Name (First, Middle, N ORE	faiden Sumame)			
Maryland	12 shows and 7 is muttraum										
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr. 900.9.		19a. Informant's Name/Relationship (Type, Print) TENEILE MOORE (DAUGHTER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1807 HOPE STREET BALTIMORE, MARYLAND 21.2 20a. Method of Disposition 1								
10	Pnysician /Medical		29a. Part: Effer the disease, or complice shock, or heart failure. List only one Immediete Cause (Final disease or condition resulting in death)	PNEWM C	he death. Do not en				Approximate Interval Between Onset and Death CAYS		
	Examiner	er		PULMO	consequence of): NARY TY consequence of):	PERTENSION			5 MONTHS		
,092	te be executed ysician and te burial-transit	cal Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):	une deficien	cy synd	ROME	5 YEARS		
.O. Box 687	ath certifical	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	livery Day Year		
<u>α</u>	requires that the de been signed by the s should be detached to	by	Part II. Dther significant conditions control HYPERTENSION,	nbuting to death but ALROMB			23e. Did tob 1 ☐ Ye	pacco use contribute to	o the cause of death?		
al Records,		Completed					24a. Was ar autops perform 1 Yes 2	y prior to o	utopsy findings available completion of cause of 2 No		
f Vital	Physiclan: Th rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	t 2 ER/Dutpatio	Diber	Death (Check only one ng Home 5 - Reside		cify)		
Division of	ding h. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		Year) Injury y - At home, farm, s	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho 28f. Location (Str. City or Town	reet and Number or Ru	ural Route Number,		
Ō	Hospital A hours Funaral ely filled	29a. Certifier (Check only Green and due to the cause(s) and manner as some coursed at the time, date and place, and due to the cause(s) and manner as some coursed at the time, date and place, and due to the cause(s) and manner as some coursed at the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course dat the time, date and place, and due to the cause(s) and manner as some course data.									
	within 2 To the complet	Mec	29b. Signature and title of certifier	and manner state		29c. License number	1	9d. Date signed (Monti			
	1/1	Y	Dan Hullolly	Y MO		RES-000	N	narch 05,	2005		
1	170		30. Name and address of person who com	npleted cause of dea	ath (Item 23a) (Type	Frint) TO NPR (10, DOCTORS (owniet, 600	N WOLFE ST	., BALTIMOR		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

				Please					of Health and M	-		egible.	
		•	1 - State Registrar			,	•		of Death		g. No:	005	07916
	Physicia			e (First, Middle, Las Love W	"UFFOLE	1+0	Jr.			2. Date of Deat Month	h Day	7 2005	3. Time of Death
	/Medic Examin		()	If not institution, give	1		4		wn, or Location of Death			ounty of Deeth	
			Universi		Mand	(10	4.5:45-6-41	f Under 1	Tear If Under 24 Hrs.	9 Date of Birth		None	lece (Stete or Foreign
	Funeral Director		5. Social Security N 218 - 28 -	9358 1	x 2□F	(In yrs. last			Days Hours Min.	8. Date of Birth (Month, Dey,	Year)	Cour	rland
	land		Usuel Residence of 10a. State	10b. County		10c. City, T	Town or Local	ion				1	0d. Inside City Limits
	Mary -1 sh	to	MD	Howard		Elli	cott C	itv					1 ☐ Yes 2 🔯 No
	r 28a	Director	10e. Street and Nu					10f. Zip Co	ode	1	0g. Citize	n of What Cour	ntry?
	deeth with the Maryland ms 23a or 28a-f show	ai D	10315 Pi	nehurst Co	ourt		2	21	042		Uni	ted Sta	ites
	sme	Funerai	11. Marital Status		12. Was Decedent E Armed Forces?		13. Wa	s Deceder es, specify	t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14	Race - Americ Black, White,	
36	or it	by Fu	1 Never Man	ried 2 Married	1XiYes 2 □ N If Yes, Give Year or Dates:1		ا ا	Yes 200	No Specify:		Si	pecify:	÷ 4. a
21215-0036	within 72 hours after deeth with the Marylan tiens - Instural, or Items 23s or 28s-1 show the Medical Exament must be notified at	ed b	2 - AAIGGMAGG	15. Decedent's Ed			16a. Deceden	it's Usual (Occupation		16b. Kind	WIT of Business/In	ite
7.	n na	piet		cify only highest grad	de completed)		(Give kir	nd of work NOT use	done during most of wor	king			
212	d within giene. r than	Completed	Elementary/Sec	ondary (0-12)	College (1-4or 5- 5+	"	Own	er			Col	lection	Agency
b	be filed ital Hygi od other event, I	Be C	17. Father's Name	(First, Middle, Last)					18. Mother's Nan	ne (First, Middle, I	Maiden Si	umame)	
<u> a</u>	should be and Mental marked o	2	Salvator	e J. Muffo	oletto, Sr				Anna Ga	llo			
Maryland	and and is m			lame/Relationship (7					street and Number or Ru				
	s 1 and 2 f Health Item 27 other tra			Muffoletto	3/ SON		e of Dispositi	-	gton Drive	-		Y, MD Z ation - City or To	
altimore,	of of			Cremation 3 🗆	Removal from State	cem	etery, cremai	tory or othe	er place)				
Ħ	C 10 3			5 Other (Specify uneral Service Licen		MO104	ro Crei		y ¦ 3ー11 ^{Address of Facility} Har			nsville - Famil	
Ba	Depart Depart Import any inj			Calles	- (i) le	MOTO			d Columbia				
0	- 6		23a. Part1. Enter	the disease, or comp	olications that caused	the death.			of dying, such as cardiac			c crey,	Approximate Interval Between
	Pnysician		Immediate Cause	(Final	one cause on each lin							4	Onset and Death
	/Medical		disease or conditi resulting in death)		a. Due to or as a	consequer	nce of):	Λ.		. 1			5072
	Examiner		Sequentially list of	onditions	b. Necro	tizin	a 50	++	tissure 1	ntection	Λ		days
	p ji	iner	cause. Enter Und	mmediate erlying	Due to or as a	consequer	nce of):						
	and and I-tran	Examin	Cause (Disease o that initiated event resulting in death)	ts 💮	cDue to (or as a	consequer	nce of):						
760,	e be executed sicien and e burial-transit			l		,	•						
687	leath certificate I attending physi I for use as the t	edic			. 0						E2001		
Вох	anding use a	Z.	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome of			ctopic pred	nancy		23	d. Date of delive	
	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 1:	□No	4☐Pregnant at			ther (spec		<u> </u>		Month	Day Year
P.0	that the de ed by tha a detached	Phy	9 Unknow						and an analysis	22a Did tal	22222	a cantributa to t	he cause of death?
	ires tha signed t be de	by	Diab	et es	ontributing to death bu	II HOL I ASUILI	ing in the drie	bilying cau	se given in Faith.	1 □ Ye	<	7	pably 4 Unknown
oro	w require been si should t	etec	Do	1 0 11	5 0	1	6			24a. Was a			aney findings available
of Vital Records,	has ge 2	Completed	Teric	heren V	ascular	acce	76.			autops	Ded	death?	psy findings available mpletion of cause of
a		e Co	25. Was case refe	arred to medical					26 Place of Dec	1 ☐ Yes	0465	1 L Yes	2200
5	Physician: this certificant ral director.	To B	examiner?		Hospital: 1 / Impatie	nt 2 EF	P/Outpatient	3□ DOA	Other	lome 5 ☐ Reside		Other (Special	(v)
	ding Phys h. After this funeral dii		27. Manner of Dea	ath	28a. Date of Injur (Month, Day	y 2	8b. Time of Injury		Injury at Work?	28d. Describe ho			
0	ath. or: After	atio	1 ⊠Natural 2 ☐ Accident	5 Pending investigation	1	70017		М	1 ☐ Yes 2 ☐ No				
Division	of or Attending after death. I Diractor: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc		e, farm, stree	t, factory,	office	28f. Location (Si City or Town		Number or Rura	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	in Certifying Ph	ysician: To the best oniner: On the basis of and manner sta	examinatio	edge, death on and/or inve	stigation, in	the time, date and place my opinion, death occu	, and due to the carred at the time, d	ause(s) ar ate and p	nd manner as s lace, and due t	tated. o the cause(s)
	To the Within To the sompl	Me	29b. Signature an	d title of certifier				29c.	icense number	2	9d. Date	signed (Month,	Dey, Year)
	/ //	Y	1 X	11/60	mill M				15212		3/	7105	
	1170		30. Name and add	dress of person who	completed cause of d	eath (Item 2	3a) (Type, Pr	int)	1 . 1		4 4		
-	1-1		JUKN	H. ADA	MUKI, N	W)	Univ	ersit	y of MARY	LAND, T	Salt	more,	MD 21301
	Sta Regist	ate rar	31. Date filed (Mo	-	32. Registra	uis Signatui	re	licas	Es.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U U Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 10:14 A M velles llian MARCH 05 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL Baltimore (
If Under 1 Year | If Under 24 Hrs. HOPK 10hns 8. Date of Birth (Month, Day, .TAN • 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Year) 1□M **XX** Yrs. 214-24-5149 90 ,1915 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or Items 23s or 28s-f show ury or other traumatic event, the Medical Exactivat raust be notified at 1X Yes 2 □ No Director MD. BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 U.S.A. 1300 S. ELLWOOD AVENUE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 X No Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 XWidowed 4 □ Divorced Year or Dates WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY PEMCO CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CONRAD WINTERLING KUNEGUNDA BUETTNER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 J WILLRICH CIRCLE, FOREST HILL, MD. MARY MADARY/NIECE 21050 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any Injury or once. SACRED HEART OF JESUS 3/8/05 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Lance License dress of Facility

ZETLER INC. FUNERAL HOME
CONKLING STREET, BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician NEUMOMIC ONEWEEK resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner that the death certificate be executed Due to (or as a consequence of): use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 5 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes Vital Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 MInpatient 2 ER/Outpatient 3 DOA Medical Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation vision 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident n 24 hours after death ne Funeral Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. mpletely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 MAL 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MENT373 BALTIMOREMARYLAND 21724 2809 BOSTON STREET, APART MATTHEW BALDWIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registra

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2005

			1 - For State Registrar	State of N	/arylan	d / Depa	artme	nt of H		nd Mer	ntal Hygi	ene	105	/9 hal /9
	Physici /Medio Examin	cal	Decedent's Name (First, Middle, La Doct 4a. Facility Name (If not institution, give		r)		4b. City		Location of		Date of Death Month 03	Day 03 4c. Count	Year 205 by of Death	3 Time of Death O
	Funeral Director		5. Social \$ ecurity Number 6. S 220–12–7257	ex 7.7 □ M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under	r 1 Year	If Under 2 Hours	Min. 8. I	Date of Birth (Month, Day, OV. 3,	Year)	9. Birthp Coun Mar	lace (State or Foreign try) Yland
death with the Maryland	or 28a-f show e notified at	Director	10e. Street and Number	timore	10c. Cit	ty, Town or Lo		ip Code		Dun	dalk	0g. Citizen of		0d. Inside City Limits 1 ☐ Yes 24☐ No try?
JSO Irs after death w	Department of Health and Mental Hygiene. Important: if Item 27 is or 28s-f show important: if Item 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Medical Examination on the notified all once.	by Funeral [7409 Holabird Av 11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? ⊈No		Was Dec If Yes, sp	edent of Hi ecify Cuba	21.222 ispanic Origin, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Ra	ced St ace - Americ ack, White, of	an Indian,
A I A I 3-0036 d within 72 hours af	giene. er than "natura . It e Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 Years	ducation de completed) College (1-40	r 5+)		kind of w DO NOT	ual Occupa ork done o use retired laker	ation during most	of working	1	6b. Kind of E		dustry
aryiand should be file	and Mental Hy marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last, Casper Rettali 19a. Informant's Name/Relationship (ata	ısband	19b. Maili	ng Addres	s (Street a		Gol	rst, Middle, M die Ma oute Number,	e Bran	mble	Code)
Saltimore, Mai Dermit. Pages 1 and 2 sh	ant of Health sit: If Item 27 Is y or other tra		Mr. Stanley A. M 20a. Method of Disposition 1X Burial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from Star	20b. F	Place of Disponentery, crea	sition (Na matory or	ame of other plac	!	Date		20c. Location	- City or To	
Dalli permit. P	Department Importarian sany injur		21. Signature of Funeral Service Lices 23a. Part1. Enter the disease or com	ner		1.79	ida−i 922 V	nd Addres UCK Vise	Funera Ave	al Hom	ne of D	iarylai	k, Inc	
be executed (I)	Medical and will transit transit	cal Examiner	Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a Du	as a consequence as a consequence	quence of):	sch	emia						Interval Between Onset and Death
Geath cert	signed by the attending phy d be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of c	al death 3]Ectopic] Other (s	oregnancy specify)		*			ate of delive	ry Day Year
ecolds, F.O.	peen	Completed by Ph	Part II. Dther significant conditions of		but not res	ulting in the u	inderlying	cause give	en in Part I.		1 ☐ Yes	s 2 □ No	3 Proba	e cause of death? ably 4 🔀 Unknown boy findings available
r ^e	is certificete has l director, page 2 s	0	25. Was case referred to medical						26. Place	of Death (C/	autopsy perform 1 ☐ Yes 2 heck only one	ed? ■ No	death?	npletion of cause of
O P	r this	Certification; To F								28d.	5 Resider	w injury occu	head	
_ =	4 hours afte Funerel Dir tely filled in I	Medical Certif	4 Homicide determined	28e. Place of building, lysician: To the beniner: On the basis and manner	etc. (Special st of my knows of examina	y) owledge, deat	h occurre	d at the tim	ne, date and pinion, death	place, and	City or Town, due to the ca	State) use(s) and m	nanner as st	ated. the cause(s)
To the	within To the comple	Med	29b. Signature and title of certifier	mar	M		2	D 2 9	number	,		od. Date sign		
0	Sta Registr		30. Name and address of person who Educated S. 33. Date filed (Month Day, Year) 2	esman	f death (Iter	m 23a) (Type,	Print)	4620	Au	e., F	Balti	nore	, MD	21224

			1 - For State Ragistrar	State of N	Maryland		artmen rtificate			and Me	ental Hy	giene	200	i in	0 *4	010
	Physic	ian	1. Decedent's Name (First, Middle, Last,)							2. Date of De		Ye		3. Time o	f Death
	/Medi Exami	cal	4a. Facility Name (If not institution, give		oseph	Mont.		Town or	Location o	of Death	3	<i>S</i> ₀ 4€	County of E		6.7	8 H M
	Exami	ler	TC VI	ire H	ospit	101	R	05	ede	~IR		1	301	+,	MO	CC.
	Funeral		5. Social Security Number 6. Se.	x 7.7	Age (In yrs. Ia	-	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	B. Date of Bi (Month, D	rth ay, Year)	9.	Birthpla Count	ace (State	or Foreign
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	show	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside C	-
	he Ma	ecto		imore			1		ows P	oint						2 J No
	with t	D	10e. Street and Number 2807 1st Street				10f. Zip	Code	21219	Ω			zen of What			
	deeth	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S	S. 13.	Was Deced	ent of Hi			ify Yes or No		ted S	merica	ın Indian,	
36	be filed within 72 hours after deeth with the Maryland hal Hyglene. d other then "neture!", or Items 23a or 28a-f show event. If a Medical Examinating the notified at	by Fu	1 Never Married 2 Married	1 ☑ Yes 2 ☐	No	1	1 ⊡ Yes 2		Specify:	, Pueno A	ican, etc.)		Black, W Specify:	/hite, e	tc.	
Maryland 21215-0036	Phour eal Ex	ed b	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates	[:] 1953	16a, Dece	dent's Usua	J Occupa						Whi:		
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and	d be fi	Be C	17. Father's Name (First, Middle, Last) John Monti						18. Mothe		First, Middle					
ary	should ind Men s marke umatic	2	19a. Informant's Name/Relationship (Ty	pe, Print) Dau	ghter	19b. Mailir	ng Address	(Street a	nd Numbe		elyn I Route Numb			ө, <i>Zip (</i>	Code)	
	₽ £ ☆ ‡		Mrs. Maragret Vale			2807	1st	Stre			more,				219	
Baltimore,	60		20a. Method of Disposition 1 □Surial 2 □ Cremation 3 □ F	lemoval from Stat	e ce	ace of Dispo emetery, crer	natory or of	her place		Da	1		cation - City	or Tow	vn, State	
Iţim			□ Donation 5 □ Other (Specify) 21. Signalure of Funeral Service License		Sac		It. of				/9/200	5	Dunda:	lk,	Mary	land
Ba	permit. Departr Importe any inje		21. Signal of Cultonal Service Cicerts	7	a. (///Du	ıda-Ru	ıck F	'unera	al Ho	me of dalk,	Dund	alk,	Inc. 212		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caus	ed the death.								<u>tanu</u>	,	Approximat Interval Bet	ie ween
	Physician		Immediate Cause (Final disease or condition	CAD											Onset and I	
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (1888 + 1949) that initiated events	Due to (or a	s a consequ	ence of):								-		
of	acuted ind transit	Examiner	that initiated events resulting in death) Last													
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit		resulting in death) Last	Due to (or a	s a conseque	ence of):										
687	ificate g phys	edicai		1.												
Вох	eath certific attending p	Physician/Me	230. Has decedent program	3c. If yes, outcom	e of pregnan		Ectopic pre	anancy				2.	3d. Date of	delivery	/	
O. E	at the dea by the att tached fo	/sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown			Other (spe						Month	D	Day 1	Year
Δ.	that the		Part II. Other significant conditions con	tributing to death	but not resul	lting in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	se contribute	to the	cause of d	leath?
rds	w requires been sign should be	ed by									1 🗆 '	Yes 2	ďNo 3□	Probab	bly 4 □L	Jnknown
Records,	a SC	Completed									24a. Was		24b. Were	autops	sy findings :	available
al R											perfo 1 ☐ Yes	rmed? 2 Ž No	death 1 ☐ Y	?	□ No	
Vital	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpar	tions 205		4 70 00	Othe			Check only o		-			
οl		P-11	27. Manner of Death	28a. Date of In	jury 2	R/Outpatien 28b. Time of Injury		c. Injury Work	at		d. Describe			рөсіту)		
sior	Attending r death. ector: After y the fune	catlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(100,101)	ay / oa/	mijory	М		es 2 🗆 N							
Division		Certification;	4 Homicide determined	28e. Place of In building,	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory,	office		28	f. Location (: City or Tox	Street and wn, State)	Number or	Rural F	Route Num.	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical C	29a. Certifier 17 Certifying Physical Check only one) 2 Medical Examination	sician: To the bes ner: On the basis and manners	of examination	vledge, death on and/or inv	occurred a restigation,	it the time in my op	e, date and inion, death	place, an	d due to the at the time,	cause(s) a date and p	and manner place, and c	as stat	ed. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		0.0	λ	29c.	License	number	3		29d. Date	signed (Mo	onth, Da	ay, Year)	
)			1 Once	4	IV	Ŋ.		15,	638	/		3/	1/0	5		
/	20+1		30. Name and address of person who co	mpleted cause of	death (Item:	^	Print)	110	Con	(1.0	Balt	- î prosi	(P M	0	212	2 7
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signatu	IONK	M =	Luc	IK YI	104	VJ. 11	1110.		· •	مام	5/_
	Registr	ar	MAR 0 9 2005	A last a	100		R. J.									

	1- State of Maryland / Department of Health and I Certificate of Death		iene _{eg. No.} 200	5 0792
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	h Day Year	3. Time of Death
/Medical	Frances Johnson Mason	3	4 2005	
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Deatl	
	FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIM	
Funeral Director	214-38-2878 1□ M 2☑F 86 Yrs. Months Days Hours Min. Usual Residence of Decedent	Month, Day, Dec. 21	Year) Co.	place (State or Foreign intry) Cginia
/land	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
death with the Maryland rms 23e or 28e-1 show rmust to indiffed at neral Director		undalk		1 ☐ Yes 2X No
with Dir	10.29 630	10	og. Citizen of What Co United Sta	,
ns 23		pecify Yes or No-	14. Race - Amer	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avent, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Was Decedent of Hispanic Origin? (State of the State	Rican, etc.)	Black, White	
n 72 hours	15. Decedent's Education (Specify only highest grade completed) [Second Second	king	16b. Kind of Business/I	
led within 72 hor ygjene. her than "natura tt, the Medical E Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Years School Teacher		Baltimore	County
d other avent		e (First, Middle, M	faiden Sumame)	
Ment Marke Martic a	Brainard Johnson Glenna			
alth and	19a. Informant's Name/Relationship (Type, Print) Mr. Donald Mason / Husband 50 South Dundalk Ave.			
nt of He t: If Item r or oth	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City or T	
irmit. Pra apartme aportant y injury ICB.	'4 □Donation 5 □Other (Specify) Hilltop Service Corp. 3/ 21. Synature / Funeral School (Specify) 22. Name and Address of Facility Duda-Ruck Funeral		Towson, Mai	4
89 = 8 9	7922 Wise Ave. Dur			222
Pnysician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPONARY ARTERY DISEASE Due to (or as a consequence of):	or respiratory arre	St,	Approximate Interval Between Onset and Death
E ial-	Sequentially list conditions, if any, leading to immediate cause. Fine Uncertify: Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
g physicia as the bur	d			· · · · · · · · · · · · · · · · · · ·
d by the attending pleached for use as the pleached for use as the pleached for use as the pleached for use as the pleached for use as the pleached for the ple	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of deliv Month	ery Day Year
be d	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to t	he cause of death?
cate has been s page 2 should Completed		24a. Was an autopsy performe	prior to co	ppsy findings available mpletion of cause of
ician: The certificate ector, pag	25. Was rasa referred to modinal	1 Yes 2	No 1 □ Yes	2□ No
ysician: is certific director,	BAdrilli Bi ?	h (Check only one)		
ng Ph	1 Kanner of Death 1 Kanner of	me 5 Residen 28d. Describe how		(y)
rs after death. al Diractor: After led in by the funers Certification:	2 Stripida 6 Could not be	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr Medical Certificati	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the cau ed at the time, date	use(s) and manner as s e and place, and due to	tated. o the cause(s)
Within To th comp	29b. Signature and title of certified 29c. License number	290	d. Date signed (Month,	Day, Year)
	18 2 1/1 MD D56477		3-4-200	5
5	30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Dr. GLENN MEININGER, 9000 FRANKLIN SQUARE DRIVE	BAITIM		
State	31. Date filed (Manth Pay Year) 2005 Registrar's Signature) 1110(111	J. J. W	//

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment rtificate			d Mental H	ygiene Reg. Ne	in the second	0.7.9	121
	Physic	an	Decedent's Name (First, Middle, La	ist)					2. Date of E Month	Death Day	Yeer	3. Time of	Death
	/Medi	cal	Carlyn May Mc 4a. Facility Name (If not institution, gir	Cray					MARCH	1,	2005	11:50	ΑM
	Exami	ner	Harford Memoria					Location of D			County of Dea arford	th	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. last birthday	If Under 1	Year	If Under 24				thplace (State or	r Foreian
	Director		217-05-2570	1□ M 2√2 F	89 Yrs.	Months	Days	Hours i	Hrs. 8. Date of 8 Min. (Month, L SEP • 2	4, 19	15 M	aryland	3
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside Cit	h. Limito
	Maryian f show	ō	MD Harfor	đ	Havre De							1 🗆 Yes	
	ith the Marylar or 28e-f show	Director	10e. Street and Number			10f. Zip (Code			10g. Citiz	en of What C	ountry?	
	th witi	ai D	102 Bayland Dri	ve, Unit 8		21	.078			U	SA		
Maryland 21215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	,	Was Decede If Yes, specif			? (Specify Yes or Nuerto Rican, etc.)		4. Race - Ame Black, Whi		
2-0	72 hours "natural"	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual	Occupa	tion		16b. Kin	d of Business	/Industry	
21	- ×	npie	Elementary/Secondary (0-12)	College (1-4or	5+)			uring most of	working				
2	44 'E L 44	S	17. Father's Name (First, Middle, Lasi)	C	afeter			None (Circl Middle			col Syst	:em
and	ould be filed Mental Hyg arked othe atic event,	o Be	Reginald Offett						Name (First, Middl t Elizabe		,		
Ž	2 shoul and Me is mark	F	19a. Informant's Name/Relationship		19b. Mail	ng Address (Street a		r Rural Route Num.			Zin Code)	
	s 1 and f Health item 27 other tr		Carol O'Brien -		102 B	ayland	Dr:	ive, U	nit 8, Ha	vre De		e, MD 21	.078
Ë			1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		Meadowri	_ ′			/5/3005	Elk	ridge,	MD	
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Lice	1500	Ga 7	2. Name and ary L. 250 Was	Address Kau Shin	of Facility fman F	uneral Ho	ome@M	leadowr	idge, MF 21075	, Inc
			23a. Pant. Enter the disease, or com shock, or heart ailure. List only Immediate Cause (Final	plications that caused one cause on each li	the death. Do not en	ter the mode	of dying	, such as car	diac or respiratory	arrest,		Approximate Interval Betw Onset and D	reen
	Physician /Medical Examiner		disease or condition resulting in death)	a. Deveve	a consequence of):	nta	(MI	altin	faret)		(several	years
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):								
8760,	cate be executed obysician and the burial-transit	dicai	that initiated events resulting in death) Last	Due to (or as	a consequence of):			-					
O. Box 6	that the death certificate be extended by the attending physician detached for use as the buria	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic prec □ Other (spec				23	d. Date of del Month		ear
rds, P	w requires that been signed t should be det		Part II. Other significant conditions of Severe Oroph	ontributing to death b	out not resulting in the u	nderlying cau	ise give	n in Part I.		tobacco use		the cause of de	
Division of Vital Records,	e la has je 2	Completed by	Urinary ta	t Infe	ction	J				ormed?	prior to death?	topsy findings av completion of cau	vailable use of
ital	icien: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?					26. Place of	1 ☐ Yes Death (Check only	one)	1 🗆 Yes	20100	
<u>></u>	Physicien: this certific al director,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Ampatie		nt 3 DOA	Other	· 4 🗆 Nursin	g Home 5 ☐ Res	idence 6 [Other (Spec	cify)	
ion o	ng fter	ation:	27. Manner of Death Matural 5 ☐ Pending 2 ☐ Accident investigatio		y Year) 28b. Time o	M 280	injury Work? 1 □ Y	at es 2 □ No	28d. Describe	how injury o	occurred		
Divis	tel or Atturs after de el Directo	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injuding, etc	ury - At home, farm, str c. (Specify)	eet, factory, o	office		28f. Location (City or To	(Street and I wn, State)	Number or Ru	ral Route Numbe	er,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one) Certifying Property and Certification Property and Certification P	ysician: To the best on the basis of and manner sta	of my knowledge, deat f examination and/or in ated	n occurred at vestigation, in	the time	, date and pl nion, death o	ace, and due to the ccurred at the time,	cause(s) ar date and pl	nd manner as lace, and due	stated. to the cause(s)	
	To t Com	W	29b. Signature and title of certifier	MIN	/	29c. I	License	number	07-	29d. Date s	signed (Month	Day, Year)	ም ረ
1			30. Name and address of person who	completed cause of	th (Item 23a) (Type,	rint)	VI	8 La	W ST	ret	ch 1	1200	201
	Sta	-	31. Date filed (Month, Day, Year)		ar's Signature	<i>y</i> R:	7	(bev	deen	Mas	TAI	6	10
	Registr	ar	MAR 0 9 2	005	as the All	Service Services				/	/		

		1	For State Registrar		State o	f Mary	/land / De	epartmen Dertificat					iene g. No. ()	05	07922
	Physicia	n	Decedent's Name RUTH	e (First, Middle, BURNS	Last) NARDON	νE						. Date of Death EBRUAR!		2°0°05	3. Time of Death 11:27P M
	/Medica Examine		4a. Facility Name (I	If not institution,	give street and nur	mber)		4b. City,	Town, o	r Location o	of Death		4c. Cour	nty of Death	
			9104 MON 5. Social Security N		DRIVE_	7 Age //	n yrs. last birth	LAUR		If Under:	24 Hrs. a	. Date of Birth	PRINC	E GEOR	
- 1	Funeral Director		099-24-67		1 □ M 2 □ XF	75		Months	Days	Hours	Min.	(Month, Day, CTOBER	3. 19	29 NEU	ace (State or Foreign try) YORK
	land DW	h	Usual Residence of 10a. State	Decedent 10b. County		10	Dc. City, Town	or Location				5-31		10	0d. Inside City Limits
	a-f sho	201	MD	PRINCE	GEORGES	L	.AUREL								1 ☐ Yes 2X No
	h with the	al Dire	10e. Street and Nu 9104 MONT		DRIVE			10f. Zip 2	Code 0708			10	U.S.	Mhat Coun	try?
36	72 hours after death with the Maryland nature!', or Itams 23a or 28a-1 show or at Example must be notified at	by Funer	11. Marital Status 1 Never Marr 3 Widowed	ied 2 Marrie	12. Was Dece Armed For d 1 Tyes If Yes, Gin Year or D	orces? 2 1 No ve	er in U.S.	13. Was Dece If Yes, spe 1 \(\text{Yes} \)	1/	lispanic Ori an, Mexican Specify:		fy Yes or No- can, etc.)		ace - Americ lack, White, o	etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dep. riment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itams 23a or 28a-1 show any injury or other traumatic event, it we wad real Examinar must be notified at once.	Be Completed by Funeral Director	(Spec		Education grade completed) College (*	1-4or 5+)	\\ \frac{9}{1}	Decedent's Usu Give kind of wo ife. DO NOT u HOMEMAK	rk done se retired	ation during most d)	t of working			Business/Ind	
yland	ould be filed Mental Hyg arkad other atic event,	lo Be C	17. Father's Name JAMES BU	IRNS						ELIZ	ABETH	First, Middle, N	V		
Mar	id 2 sho ith and 27 is m traum		19a. Informant's N		p (Type, Print) E /HUSBAI	ND		Mailing Address				Route Number, LAUREL,			Code)
more,	Pages 1 an tent of Heel not: If Item 2 iry or other		20a. Method of Dis 1 🗆 Burial 2	position Cremation	3 □Removal from		20b. Place of D	Disposition (Na	ne of	-	Dat	e [20c. Location	n - City or To	wn, State
Balti	permit. Deportments imports any inju		1 Burial 2 Cremation 3 Removal from State BALTWASH CREMATORY 3/3/05 LAUREL, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 23. The service Licensee 7601 SANDY SPRING RD. LAUREL, MD 20707												
اء	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head: alure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA													Approximate Interval Between Onset and Death
	/Medical Examiner		MILITIPLE SCIEDOSTS												
سا الله	be executed icien and burial-transit	Examiner	Sequentially list community to incause. Enter Under Cause (Disease or that initiated event resulting in death)	S	c	(oras a o	orisaquariea of	b -							
70 (ate be nysicie he bur	cai	rosuming in doutiny		d	(or as a c	onsequence of): 							
PAX 0. Box	Physician: The law requires that the death certifica this certificate has been signed by the attending phiral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	? months? □ No		oirth 2 [nant at tim	pregnancy Fetal death ne of death	3 □Ectopic p 5 □ Other (sp		/				Date of delive Month	ry Day Year
ds, P	w requires that the deben signed by the should be detached	d by P	Part II. Other signi TRACHEOS		SASTROSTO				ause giv	en in Part I.		23e. Did tob	V		e cause of death? ably 4 \(\sum \)Unknown
Division of Vital Records	he law req e has been ge 2 shou	Completed by	QUADRIP	LEGIA			_					24a. Was ar autops perform	ned?	death?	osy findings available inpletion of cause of
ital	ysician: The is certificate his director, page	a l	25. Was case refe	rred to medical						26. Place	of Death (1 ☐ Yes 2 Check only one		1 🗌 Yes	2 L No
of V	Physical this certain all direct	0	examiner?			Inpatient	2 ER/Outp					5 🕅 Reside)
on	Attending F r death. ector: After by the funer	tlon	27. Manner of Dea 1 ☑Natural 2 ☐ Accident	tn 5 🗍 Pending investiga		of Injury th, Day Y	ear) 28b. Tir	ury M	8c. Injur Wor 1 🗀	yat k? Yes 2.⊟		d. Describe ho	w injury occ	urred	
Divisi	fo the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification:	3 Suicide 4 Homicide	6 Could no determin	286. Place	of Injury ing, etc. (- At home, fam Specify)	n, street, factor	y, office		28	f. Location (Sti City or Town	reet and Nur , State)	mber or Rura	Route Number,
	Hospi 4 hou Funer ely fill	Medical	29a. Certifier (Check only one)		Physician: To the xaminer: On the b and man		amination and								
	To the To the complet	Me	29b. Signature and	title of certifier	20			29		se number				ned (Month, I	
	10	-	30 Name and add	tata	ho completed caus	Sa of door	h (Itam 22a) /T	vne Print\	ν (004770)7	1	иАКСН	1, 200	15
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	Stat Registra	* JI	31. Date filed (Mor	nth, Day, Year)	R 0 9 2001	legistrar'	Signature	H A	ente	,					

DHMH 17 Rev 1/2001

			Please	Otets of Maniford (-	•	
			1 - For State Registrar	State of Maryland /				ental Hygi	ene	07000
			Registrar 1. Decedent's Name (First, Middle, Last	41	Ceni	ificate of De		Re 2. Date of Deatl	g. Nó:• U U J	01923
	Physic	ian		7	01	10-11		Month	Day Year	3. Time of Death
A.	/Medi		4a. Facility Name (If not institution, give	etmet and number!		UEN 4b. City, Town, or Loc		MARCH	4 2cc 4c. County of De	
	Exami	ner	NORTH WEST 14			RANDAL)		MORE
å	Funeral	_	5. Social Security Number 6. Se	x 7. Age (In yrs. last bi	oirthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day,	/	rthplace (State or Foreign ountry)
	Director		218-28-0666	□M 25x 73	Yrs.	Months Days H	lours Min.	Aug 17	1931 M	d
	pu »		Usuel Residence of Decedent 10a, State 10b, County	100 City To						
	sho	'n	Md Baltimore	10c. City, Tow		Mills				10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	the N	ect	10e. Street and Number		WILLE			146	000	
	with s or	١		110		10f. Zip Code 21117		į.	lg. Citizen of What C SA	ountry?
	has 23	era	10139 Barnes Aven	12. Was Decedent Ever in U.S.	13. Wa		inic Origin? (Spec		14. Race - Am	erican Indian.
9	or Item	교	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		as Decedent of Hispa es, specify Cuban, N		ican, etc.)	Black, Wh	ite, etc.
03	ral', c	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	∃Yes 2∭X No S	pecify:		SpecifyWhi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be ricitified at	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	ication 16a	a. Deceder (Give kir	nt's Usual Occupation nd of work done durin NOT use retired)	ng most of working	1	6b. Kind of Business	s/Industry
121	within an e.	mp	Elementary/Secondary (0-12) 12	College (1-4or 5+)		NOT use retired)			animal ca	re
d 2	Hygie Hygie Ither	ပိ	17. Father's Name (First, Middle, Last)		408		Mother's Name			
an	d be ental ked o	To Be	David Chaffman			}	rene Rob		aloon oumamo,	
Maryland	shoul nd M marl	-	19a. Informant's Name/Relationship (T)	/pe, Print) 19t	b. Mailing	Address (Street and	Number or Rural	Route Number	City or Town, State.	Zip_Code)
ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, the Medical Examiner must be profitted at ance.		Eldon C. Owen (sp	ouse) 1	.0139	Address (Street and a Barnes Av	re., Owin	ngs Mill	s, Md 211	17
Baltimore,	of He of Her		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place o cemete	of Dispositi	ion (Name of tory or other place)	Da		Oc. Location - City o	
Ĕ	Pag ment ant: t		'4 Donation 5 Other (Specify)	Tomovariiom State		Memoria1	3-9-05	5 S	ykesville	, Md
3alt	permit. Departi Import any inj		21. Signature Funeral Service Licens	99 /	22. N	Name and Address of	Facility Haig	ht Fune	ral Home	& Chapel
	₹ ○ = ₹ ∂		ouun c	talgyt	P.0). Box 195	Sykesvi	11e, Md	21784	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death. Do ne cause of each line.	not enter				st,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Peri	Ton	eal (Lance	-		Oliset and Death
	/Medical Examiner		1	Due to (or as a consequence	e of);	8				
		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):					ļ
	ate be executed nysicien and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events							I
0,	exec en an rial-tr		resulting in death) Last	Due to (or as a consequence	of):					
760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	icai		d						
89	ndiffica ng ph a as tl	Med	IF FEMALE:						I	
Вох	death certificate b attending physic I for use as the b	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	h 3□Ed	ctopic pregnancy			23d. Date of de Month	
0.	at the dea by the a stached for	Physician/Med	1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	5 🗆 0	ther (specify)			Worth	Day Year
Р.	that the ed by detac		Part II. Other significant conditions con	ntributing to death but not resulting i	in the unde	arlying cause given in	Part I	23a Did toba	icco use contribute t	o the cause of death?
Records,	signed d be det	d by	3	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	m and and	onying sauce given in	T WITE		2 □ No 3 □ P	
SOL	w require been sig should b	ete						-		
Re	he lav e has ge 2	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
		ပိ	25. Was case referred to medical				Diagonal Dorah	1 ☐ Yes 2	No 1 □ Yes	3 2 □ No
<u> </u>	90 9	OB	eyaminer?	Hospital: 1 Impatient 2 ER/Ou	utnatient	Othor	Place of Death (ce 6 ☐Other (Spe	vci6./
	ig Physi ter this o	F.	27. Manner of Death	28a. Date of Injury 28b.	Time of Injury	28c. Injury at Work?	1000		injury occurred	iony)
ior	E & . E.	atio	1	(Month, Day rear)	irijury	M 1 ☐ Yes	2 🗆 No			
Division	I or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street	, factory, office	28	f. Location (Stre	et and Number or R State)	ural Route Number,
	urs aff		/							
	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knowledge ner: On the basis of examination an	e, death oo nd/or inves	ccurred at the time, di tigation, in my opinion	ate and place, an n, death occurred	d due to the cau at the time, dat	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the within 2 To the complete	Mec	29b. Signature and title of certifier	and manner stated.		29c. License nur			I. Date signed (Mont	
	γ 3 ⊢ δ	1		//		257				
1	18	1	30. Name and a ress of person who co	empleted cause of death (Item 23a)			V	1	1ARCH 4	2005
J	7 (LEONARD RICHARDSON			ROAP RAN	VOALLSTO	DWN ME	21133	
*	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature		,	711		-0.7	
1	Registr	ar	MAR 0	9 2003 Alassa	K	Breaker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item, 3 per phys., 8841 3-10-05 byt.

			Amend item 3 per phys. 28 State of Maryland Pl 1- For State Registrar	341 3-10-0 department of Certificate of			ene, 005	07924
	Physici /Medio		Decedent's Name (First, Middle, Last) VIOLET LORENE PLUDE			2. Date of Death Month	Day Year	3. Time of Death 3:00a м
	Examir		4a. Facility Name (If not institution, give street and number) 1311G Sheridan Place		n, or Location of Dea	March March	4 2005 4c. County of Dea Harford	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	thday) If Under 1 Ye			Year) 9. Bir	thplece (State or Foreign buntry) rginia
	Maryland -f show	tor	Usual Residence of Decedent					10d. Inside City Limits Yes 2 \(\text{No} \)
	with the	i Direc	10e. Street and Number 1311G Sheridan Place	10f. Zip Coo	015	10	g. Citizen of What Co	
3036	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel', or items 23a or 28e-f show any righty or other traumatic event, the Modical Exacting russible notified at ance.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- no Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
21215-0036	led within 72 h ygiene. her than "natu it, ire Medica	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) F	Decedent's Usual Oc (Give kind of work do life. DO NOT use re lomemaker	one during most of wo atired)	orking	6b. Kind of Business. Own Hom	·
Maryland	iould be fil I Mental H varked ott	To Be	17. Father's Name (First, Middle, Last) Trevor Marshall		Viola	a Bowman		
ore, Mar	es 1 and 2 sh of Health and filem 27 fs m r other traum		James E. Turman/Son 1 20a. Method of Disposition 20b. Place of	. Mailing Address (Str L22 Hutchi Disposition (Name of ry, crematory or other	ns Street,	Batavia,		0
Baltimore,	permit. Pag Department Importent: f any injury o		Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeyal Service Licensee	/ernon Ceme 22. Name and Ac Harkins Fu		01044001040404	Whiteford	DANC BROKEBOO
18	Physician /Medical Examiner the primaritansit	dical Examiner	23a Faul English disease or commissions that ceused the death. Do not so that ceused the death. Do	of): tens	path	correspiratory arres	st,	Approximate Interval Between Onset and Death MONTH
.O. Box 6	that the death certificated by the attending posterior use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date of del Month	ivery Day Year
rds, P	quires that n signed b		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	e given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ai Record	Physiclan: The law requires that the this certificate has been signed by th al director, page 2 should be detach	Completed	hyperlipidemin			24a. Was an autopsy perform	prior to	itopsy findings available completion of cause of 2 \(\simega\) No
Vital	/siclar s certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA	Othor	ath (Check only one)) ice 6 ⊡Other (Spe	cifu)
Division of	ttending Phydeath. ctor: After thi		27. Manner Death 28a. Date of Injury 28b. T	Time of 28c. I	Injury at Work? 1 🗆 Yes 2 🗀 No	28d. Describe how		,,
Divis	or A after Direction by	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, offi	ice	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	d/or investigation, in m	ny opinion, death occ	urred at the time, dat	e and place, and due	to the cause(s)
	with To	~	29b. Signature and title of certific	MD 29c. Lic	D2813	6	d. Date signed (Mont)	2.005
	10		30. Name and address of person who completed hause of death (Item 23a)	Type, Brint)	MD 2	1014		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2005	1				

	1 State Registrar 1. Decedent's Name (First, Middle			Certificate of	Death	Reg	l. No.	0792
ician	Maerine		Line			Month March	Day Year	3. Time of Deat
dical	4a. Facility Name (If not institution			4b. City. Town, o	r Location of Death	MARCH	4c. County of Dea	
niner	Sinai Hospi	-		1 ~	more Ci	tu	٨/ .	/1
al	5. Social Security Number	6. Sex	. Age (In yrs. last b	irthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or For
or	228-46-6187	1□M 212F	70	Yrs. Months Days	Hours Min.	Month, Day, Y	1934	N C
	Usual Residence of Decedent		10.00.7					
_	10a. State 10b. County	1.		wn or Location				10d. Inside City Lir
Director	MD N	<u> </u>	13	altimore				
ral Director	10e. Street and Number	1 0.	n 1 2.	10f. Zip Code	. 7	100	J. Citizen of What Co	ountry?
Funeral	0613 Eber	le Drive-	ent Ever in U.S.		1215	city Ves or No-	14. Race - Ame	S #9
F	1 Never Married 2 Marr	Armed Ford	es?	13. Was Decedent of H	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dat		1 ☐ Yes 2 ☑ No	Specify:		Specify:	3 lack
Completed	15. Deceden	t's Education	16	a. Decedent's Usual Occup	ation	16	b. Kind of Business	
ple	(Specify only highes Elementary/Şecondary (0-12)	College (1-4	4or 5+)	(Give kind of work done life. DO NOT use retired	auring most of worki d)	ng	_	
Con	150		<u></u>	Doney			Prive	Le
Be	17. Father's Name (First, Middle,	Last)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	•
2	Sandy Wi	1cox					Ferson	
	19a. Informant's Name/Relations			b. Mailing Address (Street				
	Celestineh	1.1COX/ni		of Disposition (Name of	erle Dne	ve-Aph.	302 Balt	choice MDZ
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S	tate cemet	ery, crematory or other place	(e) 5 /	A18 20	c. Location - City or	Town, State
	`4 □ Donation 5 □ Other (S	pecify)	Mt	22. Name and Address Harri F	1 3/10	105 4	ansdown	R MB
Suce	21. Signature of Funeral Service	Licensee		22. Name and Addre	s of Facility Se	Funera	I ser	vice, P
ч	7			1 5126 3	Clay R Re	140, Ba	imone	MDUZU
7	23a. Part1 Enter the disease, or shock, or heart failure. List	only one cause on ear	ch line.	o not enter the mode of dyir	ig, such as cardiac o	r respiratory arresi	t,	Approximate Interval Betweer Onset and Death
in	Immediate Cause (Final disease or condition resulting in death)		515	710075				24 ho
al er	, recently in county		r as a consequence					200
- E	Sequentially list conditions, if any, leading to immediate		r as a consequence	Aeidosis				07 100
Examiner	Cause (Disease or injury		11	Hypertens	Sian			5 uea
Exal	that initiated events resulting in death) Last		r as a consequence		,,,,,			- 0-
705		d						
edle								
Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Detail deat	h 2 Estado programas			23d. Date of de	livery
icla	in the past 12 months?	4□Pregnai	nt at time of death	th 3 Ectopic pregnancy 5 Other (specify)	, 		Month	Day Year
hys	9 Unknown	9∐ Unknov	vn					
by P	Part II. Other significant condition	ns contributing to dea	th but not resulting	in the underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death
						1 🗆 Yes	2ND No 3□Pr	obably 4 Unkno
Completed						24a. Was an autopsy	24b. Were au	topsy findings available
E O						performe	d? death? INo 1 □ Yes	2 No
Be (25. Was case referred to medical examiner?				26. Place of Death			
10	1 Yes 2 No	Hospital: MIng	patient 2 ER/C	Outpatient 3 DOA	er: 4 🗌 Nursing Hor	ne 5 Residenc	e 6 Other (Spe	city)
ino in	27. Manner of Death 1 ✓ Natural 5 ☐ Pendin	28a. Date of (Month,	Injury 28b. , Day Year)	Time of 28c. Injury Wor	y at k?	8d. Describe how	injury occurred	
catle	2 Accident investig	gation			Yes 2 □No			
Certification;	3 Suicide 6 Could at determine	ined 289. Place 0	of Injury - At home, t g, etc. <i>(Specify)</i>	farm, street, factory, office	2	28f. Location (Street City or Town, S	et and Number or Ri State)	ural Route Number,
		- W						
a	(Check only 2 Medical	Examiner: On the bas	sis of examination a	ge, death occurred at the tin ind/or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
2	one) 29b. Signature and title of certified	and manne	er stated.	29c. Licens			. Date signed (Mont	
Medical	,	101	0 -					
Medic	1)-4.	V \ /I				h A	أسأ امادها	
Medic	Patries	M	MD		- 000	P	larch 4	, 2005
Medic	30. Name a address of person Patrice h	who completed cause	of death (Item 23a				iltimor	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registre MEND ITEM #16b PER FH G841 Gentling Gate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year Clarence J. Pinchback 1:26AM 03 04 05 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Avenue 3040 GranHey Baltimore) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1⊠M 2□F 81 Yrs. 229-16-7690 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinatinust be notified at MD Baltimore **Funeral Director** 1 Yes 2 □ No Items 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3040 Grantlei Avenue 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No "netural', or 1 ☐ Yes 2 ☐ No Specify: Black Completed by lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) oveman Batt 12 Higrade BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pinchback John Amanda ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 Is any injury or other trau QDCs. Dorothy M. Pinchback Paltimore MD 21215 314E Grantley Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 03.11.05 Baltimore MA 1 4 ☐ Donation 5 ☐ Other (Specify) Loudon Pane 21. Signature of Funeral Service Licensee Vaugus C. Greene Funeral Services 5151 Baltimore National Pite Baltimore MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Desease 1 Yes 2 No 3 Probably 4 Unknown ser te 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ After thi 27. Manner of Beath 1 Alatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2020 D26748

Registrar DHMH 17 Rev 1/2001

State

ANIT 31. Date filed (Month, Day, Year)

MAR 0 9 2005

FALLS (40

BALTOMD 21211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

			State of Maryland / Department of Health and	-	_	5 07927
			Registrar Certificate of Death	2. Date of Deat	g. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JOHN F • POOLE	February		3. Time of Death 12:05 AM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D	Death	4c. County of D	
			Upper Chesapeake Medical Center Bel Air 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24	Hre la Day (Ditt	Harf	
ı	Funeral Director		215-32-0941 1 M 2 F 86 Yrs. Months Days Hours N	Hrs. 8. Date of Birth Min. 9/16/19	18 Ma:	Birthplace (State or Foreign Country) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	7-4		10d. Inside City Limits
	death with the Maryland ims 23e or 28e-f show r nast be notified at	tor	MD Harford Whiteford			1 ☐ Yes 2 No
	h the	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What	Country?
	th wit		4610 Graceton Road 21160		USA	
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)		merican Indian, /hite, etc.
20	hours after turei', or Ite	by Funerai	1 Never Married Married 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify: W]	·
9500-61212	n 72 hours atter death with the Marylan "neturel", or Items 23e or 28e-f show scilical Evaninar mast ke notifiad at		15. Decedent's Education 16a. Decedent's Usual Occupation		6b. Kind of Busine	
Ċ	within 72 ene. then "nel	piet	(Specify only highest grade completed) (Give kind of work done during most of life, OO NOT use retired)	working	OD. KING OF BOOKING	as in destry
7 7	d with	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Carpenter		Home Im	crovement
	be filed within tal Hygiene. d other then event, tre M	Be (Name (First, Middle, A		
yland		To	-	Elizabeth		
Mar	C/ 10 = 0		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of		-	
	l an deal leal ther		Anne H. Poole/Wife 4610 Graceton Road, 20a. Method of Disposition 20b. Place of Disposition (Name of		, MD ZI.	160
Baltimore,	8 = 5		1 M Burial 2 Cremation 3 D Bernoval from State cemetery, crematory or other place)	11.		
	permit. Pag Department Importent: any injury once.		4 ☐Donation 5 ☐Other (Specify) 21. Sign out of Feneral Service Licensee 22. Name and Address of Facility	4/2005	Pylesvill	re, MD
r C	permit. Departr Importa		Harkins Funeral Home,	Inc. 600 Mair	St. Delta	. PA 17314
	_		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care / shock, or heart failure. List only one cause on each line.			Approximate
	Pnysician-	81 1	Immediate Cause (Final disease or condition RES PIRATORY FAIWRE			Interval Between Onset and Death
	/Medical		Due to (or as a consequence of):			
	Examiner	_	Sequentially list conditions, b. PNEUMONIA			
T	pei isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
V	be executed ician and burial-transit	xan	that initiated events ' c. resulting in death) Last Due to (or as a consequence of):			
/bū,	eath certificate be executed attending physician and for use as the burial-transit	cail	d ======			
Q	certificat Iding ph) Ise as th	edi				
ž Q	th cer lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	
	e death the atter	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ves 2 No 9 Unknown		Month	Day Year
Į.	that the de led by the a detached i	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did toh	acco use contribute	e to the cause of death?
as,	200	d by	AMEMIA		s 2□No 3□	4
ecora	~ Q 70	Completed	DIARETES MELLITUS TYPE Z	24a. Was ar		autopsy findings available to completion of cause of
Ľ	The law cate has page 2 s	Con	CORMARY ACTERY DISEASE	perform		1?
VII	iyslcien: Th	Be	evaminer'/	Death (Check only one		
0	Physicien: this certific ral director,	. To	1 Yes 2540 Hospital: Papatient 2 ER/Outpatient 3 DOA Other: 4 Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ng Home 5 Reside		pecify)
Sion	ding h. After fune	tion	1-Matural 5 Pending (Month, Day Year) Injury Work?	260. Describe 110	w injury occurred	
	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28f. Location (Str	eet and Number or	Rural Route Number,
<u> </u>	a after	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town	State)	
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edicai C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or	lace, and due to the ca	use(s) and manner	as stated.
	To the h within 24 To the F complete	Med	one) and manner stated			
	To To	П	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mo	W 78 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	O Charles A.D.	SAVE D	2
	20		Annton W. Amphilia DD. Ros Ala	R MO	21014	4 28, 2005 R.
	Sta	te	31. Date filed (Montal, Day, Tear) 32. angistrar's Signature	- 1 4		
	Registr		MAR 0 9 2005			

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				partment of Health and Mental I	Hygiene Reg. No. 2005 07928		
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Leoba M. Petty	2. Date o Month Marc	f Death 3. Time of Death		
	Exami		4a. Facility Name (If not institution, give street and number) ROSSVILLE Manor Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Rossville 4c. County of Death Baltimore			
	Director		216-18-4492 1□ M 2☑F 81 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1		9. Birthplace (State or Foreign Country) 0,1924 Maryland		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28e-f show any injury or other treumatic event, it whe dical Evantrer must be notified at Once.	ector			10d. Inside City Limits 1 ☐ Yes 2 ☐XNo		
		Funeral Director	1711 Turkey Point Road	10f. Zip Code 21 221	10g. Citizen of What Country? USA		
		To Be Completed by Fune	3€Vidowed 4 □ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc., □ Yes	14. Race · American Indian, Black, White, etc. SpecifyWhite		
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 16a. Dec (Giv life. HO	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) DMEMAKET	16b. Kind of Business/Industry Own home		
Maryland			17. Father's Name (First, Middle, Last) Daniel Edell	18. Mother's Name (First, Mid Matilda	dide, Maiden Sumame)		
				ling Address (Street and Number or Rural Route Nu Haslett Road Joppa			
Baltimore,			20a. Method of Disposition 20b. Place of Disposition 20c. emetery, or		20c. Location - City or Town, State Baltimore MD		
Balt			K. Terry Connelly	300 Mace Ave. Balt	yFuneralHomeofEssex		
	Enysician /Medical Examiner	edical Certification; To Be Completed b	23a. Part I. Enter the disease, or completations that caused the death period enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atteroscientic Carcles vascular Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		y arrest, Approximate Interval Between Onset and Death		
.O. Box 68760,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.				
				□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year		
rds, P.			Part II. Other significant conditions contributing to death but not resulting in the		id tobacco use contribute to the cause of death?		
Ě			25. Was case referred to medical	pe 1 ☐ Yes	prior to completion of cause of death? 1 Yes 2 No		
of			examiner? 1		ly one) esidence 6 □Other (Specily) pe how injury occurred		
É			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)		
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the treatment of the time of the time.	he cause(s) and manner as stated. le, date and place, and due to the cause(s)		
)	T with	Σ	29b. Signature and title of certifier	29c. License number D 30 64-1	29d. Date signed (Month, Day, Year) 08 March 2005		
	p		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Rame (h. Sahapahu 20) 109 Back 31. Date filed (Month, Day, Year) 32. Registras Signature MAR 0 9 2005	CK RIVEY NICK ROAC	Baltime Mayland		
	Sta Registr	4	31. Date filed (Month, Day, Year) MAR 0 9 2005	Sparte	,		

Amend Items: 10f & 20b per F.H G-841 3/9/05 reb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** MARCH 5, LAWRENCE **POWERS** 10:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2111 OUR LANE LUTHERVILLE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN. 17, 1935 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 **X** M 2□ F Days Hours Min Yrs 212-34-9118 70 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygleine. Importent: if item 27 is marked other than "neturel", or items 23a or 28e-f show any lighty or other treumetic event, it is Medical Evantre trust be notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Be Completed by Funeral Director BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21153 2111 OUR LANE 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY AT LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TEMPLE **POWERS** DOROTHY RUBENSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11831 SHERBOURNE DRIVE - TIMONIUM, MD 21093 SHERYL POWERS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State /08/05 1 Burial 2 Cremation 3 Removal from State
1 Donation 5 Other (Specify) HILLTOP SERVICE CORP.: 0308/2005 TOWSON, MD 21. Signatury Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Pnysician /Medical physician and s the burial-transit

Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, been signed by the attending p should be detached for use as within 24 hours after death. Yo the Funerel Director: A completely filled in by the to

Baltimore, Maryland 21215-0036

23a. Part1/Enter/the disease, or co shook, or heart failure. List or	 Part1/Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 						
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):					Onset and Death		
Sequentially list conditions, and leading to the form of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to for as a consequence of consequen							
IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1					23d. Date of deliv Month	3d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to							
				24a. Was an autopsy performed? 1 ☐ Yes 2 X No	prior to co death?	opsy findings available ompletion of cause of 2 No	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home Re			lome Residence	sidence 6 Other (Specify)		
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) on	28b. Time of 28c Injury M	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. D [®] scribe how injury occurred			
3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, factory, o	office	28f. Location (Street ar City or Town, State	nd Number or Run e)	al Route Number,	
29a. Certifier Check only one) Certifying F	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death occurred at ation and/or investigation, in	the time, date and place my opinion, death occu	and due to the cause(s tred at the time, date an) and manner as s d place, and due t	stated. o the cause(s)	
29b. Signature and title of certifier	110	29c. L	icense number	29d. Da	te signed (Month,	Day, Year)	
1///	X (/1 /2		07931	7 M	rale 7	700	

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MASON-JONES, LUCH H

			Please 1	Type or Print in Black In		•	_		
		•	1 - State Registrar	State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygier Reg.	/1115	07930	
	Physici	cal	Decedent's Name (First, Middle, Last		••	2. Date of Death	Day Year	3. Time of Death	
	/Medic		4a. Facility Name (If not) institution, give	ON KLEVES + JONE street and number)	4b. City, Town, or Location of Death	MARCH	3 2005 4c. County of Death		
	Examin		SINAL HOSPITAL	OF BALTIMORE	BALTIMORE			NA	
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	intry)	
Maryland 21215-0036	ס	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1 700.	10d. Inside/City Limits	
	Maryla		WP		altimore			1 ØYes 2 □ No	
	be filied within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or itams 23a or 28a-1 show evant, if a Medical Erandinal must be notified at	Director	10e. Street and Number 2409 W. Lanvo		10f. Zip Code	10g.	Citizen of What Cou	intry?	
	death	Funeral	11. Marital Status	0001	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Oban, Mexican, Puerlo	ecify Yes or No-	14. Race - Ameri		
	s after	Be Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 MNo Specify:	r rican, etc.)	Black, White,	IN DV	
	72 hour		15. Decedent's Edu (Specify only highest grad	ication 16a. Dec	edent's Usual Occupation e kind of work done during most of work	tina 16b	. Kind of Business/In	H CA ndustry	
	withIn ene, than "		Elementary/Secondary (0-12)	Scollege (1-4or 5+)	DO NOT use retired)	9	Media	.1	
	be filed tal Hygid d other evant, I		17. Father's Name (First, Middle, Last)	0 4.0	18. Mother's Nam	e (First, Middle, Maid	len Sumame)		
	should be nd Mental marked c	ို	19a. Info lant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City				ty or Town State Zi	in Code)	
	nd 2 lith a 27 is r trau		Norman V. Reeve	S III (Grandson) 372	2 Winterbourne	Rd. B	altimore.	MD. 21216	
Baltimore,	Pages 1 arment of Healunt: If item		20a. Method of Disposition 1 D Burial 2 Cremation 3 DF	removal from State	ematory or other place)	Date 20c.	. Location - City or	own, State	
altin	글로판를 .		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licence	0.11.01	OS CEMETEN D-M- 22. Name and Address of Facility (1)	ahn C.G		what shos	
<u>~</u>	Depa Impo any i		> Vaugh CI	8	728 Liberty Rd. 4	tallations	ow MD	21133	
	Pnysician	. 10	shock, or heart failure. List only o Immediate Cause (Final	•	nter the mode of dying (stich as cardiac	or respiratory arrest,	Į.	Approximate Interval Between Onset and Death	
	/Medical Examiner		disease or condition resulting in death)	aPNEUNONIA Due to (or as a consequence of):				40 DAYS	
		Examiner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	be executed sician and burial-transit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
760,	te be ex ysiclan e buria	a		d					
x 687	death certificate e attending phys id for use as the	Medi	IF FEMALE:	23c. If yes, outcome of pregnancy		,			
. Box	death cer e attendin d for use	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐*Other (specify)		23d. Date of deliv Month	Day Year	
P.0	that the de ed by the detached	e Completed by Phys						co use contribute to the cause of death? 2 \[\text{No} \] 3 \[\text{Probably} \] 4 \[\text{Nhnown} \]	
of Vital Records,	sign d be		A						
	law 2 s		CHRONIC OBSTRA	CTIVE PULHONAR	LY DISEASE	24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of	
	T ate		25. Was case referred to medical		26 Place of Dea	1 Yes 2 A	No 1 Yes	2 No	
	Physician: this certific ral director,	္	examiner? O 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6					ify)	
	ing After	Certification;							
Division	F 6 F C	rtifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,	
	To the Hospital of within 24 hours af To the Funeral D completely filled in			sicien: To the best of my knowledge, dea					
	the Ho hin 24 I tha Fu mpletely	Medical	one)	iner: On the basis of examination and/or i and manner stated.	investigation, in my opinion, death occur		and place, and due t Date signed (Month,		
)	C # C Ø		29b. Signature on title of certifier	M.D.					
	i()(1		1 11	ompleted cause of death (Item 23a) (Type			ARCH 3. a	BELVEDERE AVI	
	Sta	ite	MARIA STEPHANIE 31. Date filed (Month, Day, Year)	N. JAROELE 7A MO S 32. Registrar's Signatur	SINAL HOSPITAL OF E	MLTIMORE	BALTIMORE	, MD 21212	
	Registi		MAR 0 9 2005	Blowner A 19					

State Registrar DHMH 17 Rev 1/2001

MAR 0 9 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death 2000 S **Physician** 8:15 leed 04 Carr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Baltimore Riverview Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 F Yrs January 31 1915 Perry Hall, Md. Director 216 10 9162 90 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel; or items 23a or 28a-1 show any injury or other treumatic event. If a Marylasi Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 No Directo Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 USA 4526 E Joppa Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ₩ ∐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Harry T Campbell Co. N/A Concrete Mixer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nellie Gambrill David Henry Reed Sr ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8813 Blairwood Road Apt. A4 Baltimore, Md. 21236 Arleen Parcover (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mam. Park March 8 2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7401 Belair Road Baltimore, Md. 11256 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) especta **Physician** 0207 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nkhown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 Yes 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No Certification: To 4 ☐ Nutsing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1-ENatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗍 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 - Homicide within 24 hours a To the Funerel C 🗠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D19667 Keepours verview Mussing Home who completed cause of death (Item 23a) (Type, Rrint) 30. Name and address of perso 32. Registrar Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1115 For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Harriett. W. Rappold 2005 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner SQUARE Rosedale
If Under 1 Year If Under 24 Hrs. pilA 405. more 5. Social Security Number 7. Age (in yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Min. Yrs. Director December 26 1924 | Baltimore, Maryland 219 18 3800 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** Baltimore Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1803 Willann Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Stenographer Monumental Life Insurance Co Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental John Roval Rosenberger Sylvia Esslinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If item 27 is eny injury or other treuonce. 1803 Willann Road Baltimore, M. 21237 co of Disposition (Name of Date 20c Clarence J Rappold Jr (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. March 11 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Some tire of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acale M disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) isigned by the sid be detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No edema Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Alatural 2 Accident 5 Pending within 24 hours after deam.

To the Funerel Director: At 1 ☐ Yes 2 ☐ No investigation hours after death. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier-RES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DR. BALTIMORE Md. 21237 NegailA 31. Date filed MAR DV. Gear 2005 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Marylan		artment of I rtificate of			ne 0 0 !	5 07933
	Physic	ian	1. Decedent's Name <i>(First, Middle, Last</i> Delores	elmira	Roys	ter		2. Date of Death Month March 1,	2005 Y	3. Time of Death 11:20Pm M
	/Medi Examir		4a. Facility Name (If not institution, give 112 Sherman Road	street and number)	noyo		or Location of Dea		4c. County of [
	Funeral Director		5. Social Security Number 6. Se 061-32-6949 10 Usual Residence of Decedent	x 7. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Year Months Days			9. 939 V	Birthplace (State or Foreign Country) Vashington DC
	e Maryland Ba-f show	Director	10a. State 10b. County Maryland Charles		y, Town or Lo Wa	ldorf				10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 2	al Dire	10e. Street and Number 112 Sherman Road			10f. Zip Code 2060	02	10g.	Citizen of What	Country? U.S.A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show appringury or other treumatic event, the Medical Examinat must be routilled at ODGe.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 21 No If Yes, Give 1 Year or Dates:	!	Was Decedent of H f Yes, specify Cub 1 ☐ Yes Z No	dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, V Specify:	merican Indian, Vhite, etc. White
21215-0036	within 72 ho ane. then "natur ie Medical i	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	cation e <i>completed)</i> College (1-4or 5+)	(Give life. 1	dent's Usual Occup kind of work done OO NOT use retire	during most of wo d)	rking). Kind of Busine	•
Maryland 2	uld be filed fental Hygis rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Thomas 011 is	e Harl		tory Mana	18. Mother's Na	opec. Go me (First, Middle, Mai Catherine	overnmen den Sumame) Proct	
	and 2 shouealth and Nm 27 Is mainer treumainer.		19a. Informant's Name/Relationship (Ty James W. Royste	гре, Print) r, Jr.	19b. Mailin	112 Sherm	and Number or Ri	Waldorf, N	ty or Town, Stat	e, Zip Code)
Baltimore,	Pages 1 ment of H ent: If ite ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State	emetery, cren	sition <i>(Name of</i> natory or other place Memorial	_	:n /,	Location - City $it1$ and,	or Town, State Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	and 100257	(6633 01d	Alexandr			nc. nton, MD20735
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death te cause on each line.	nd s	the mode of dyin	ig, such as cardial		it fails	Approximate Interval Between Onset and Death
8760,	cate be executed physician and ithe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	nitra	lionny f Reli	spalto ourgito	turs		
Box 6	death certifi e attending d for use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	felivery Day Year
rds, P.	sign be	by	Part II. Other significant conditions con	tributing to death but not resu	lting in the un	derlying cause give	en in Part I.	23e. Did tobacc		to the cause of death?
al Records,		Completed						24a. Was an autopsy performed 1 Yes 2 💢	prior t	autopsy findings available o completion of cause of ?
X	yeiclen is certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔯 No	ospital:	R/Outpatient	3□ DOA Othe	_	th (Check only one)		
n o	ding Phy h. After thi funeral	on: T	27. Manner of Death 1 (A) Matural 5 (1) Pending	Tan 5	28b. Time of Injury	28c. Injury Work	at	ome 5 Pasidence 28d. Describe how in		pecify)
Division of Vital	lel or Attending Phyeicien: s after death. al Director: After this certifica ed in by the funeral director, i	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre		/es 2□No	28f. Location (Street City or Town, Sta	and Number or lite)	Rural Route Number,
	Hospi 4 hou Funer ely fill	edical	29a. Certifier (Check only one) 1 Sertifying Phys 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the cause rred at the time, date a	s) and manner and di	as stated. ue to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. License	number 45	737 290.0	ate signed (Moi	
	il		30. Name and address of person who cor						-1	
	Stat Registra	9	Nirmaladevi Gurus 31. Date filed (Month, Day, Year) MAR 0.9	32. Registar's Signatu 2005	8 Uld	Washingto	on Road I	Waldorf, Ma	ryland	20602-3204

			1 - For State Registrar	State o	of Marylar		artment of F rtificate of		d Mental Hy	giene Reg. No. 0	05	07934
	Physici /Medio		1. Decedent's Name (First, Middle, Kathleen Mullar		ack	-			2. Date of De. Month March	ath 2, Day 2005	Year	3. Time of Death 8:15 am M
	Examir		4a. Facility Name (If not institution, 1526 Ellsworth		mber)		4b. City, Town, o		eath	4c. Count	y of Death Arund	
	Funeral Director		214-78-0707	5. Sex 1 ☐ M 2 💢 🏋	7. Age (In yrs. 44	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		, Year 1960	9. Birth Cou Wash	place (State or Foreign ntcy) nington, D.C
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23s or 28s-f show event, it is Madical Examinat must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number	Arundel		ty, Town or Lo	cation			10g. Citizen of		10d. Inside City Limits
	s 23a or		1526 Ellsworth				2111			United	Stat	es
3036	ours after de irai', or item LExamination	d by Funeral	11. Marital Status 1 Never Married Ammarrie 3 Widowed 4 Divorced	Armed Fo	2 XX 0		Was Decedent of H	dispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No- lerto Rican, etc.)		ce - Americk, White, fy: Whi	
Maryland 21215-0036	be filed within 72 hours after death with the Maryian Ital Hygliene. Id other than "natural", or items 23s or 28s-1 show event, it is Mariteal Examination at 15 per rollified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College ((Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of E		dustry
and	should be filed and Mental Hygi s marked other rumatic event, I	To Be C	17. Father's Name (First, Middle, La Joseph Mullaney	•					Name (First, Middle, ine Sevigi		me)	
Mary	id 2 should be th and Mental 27 is marked (17 is marked (-	19a. Informant's Name/Relationshi Brian Rohrback/			19b. Mailin 1526	g Address (Street Ellswort	and Number or th Stre	Rural Route Number	r, City or Town	, State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Importent: If item 27 is marked any Injury or other traumatic e ones.		20a. Method of Disposition XXBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Chair	emetery, cren	sition (Name of natory or other place ion Cemet		Date ar.5,2005	20c. Location	-	
Balt	permit. Departr importe any inje		21. Signature of Funeral Service Li	censee			Name and Address Ridgely		Hardesty I			
98/60,	the death certificate be executed X The attending physician and cheef for use as the burial-transit	edical Examiner	23a. P. rt1 Enter the disease, or chock, or heart failure. List of hock, or heart failure. List of limit of a Cause (FWall disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pa Due to b. Due to c	ancreati (or as a conseq (or as a conseq (or as a conseq (or as a conseq	c Cancuence of):		g, 3301 43 0a1	inco or respiratory at	GS1,		Approximate Interval Between Onset and Death
O. BOX	the death certific y the attending p tched for use as	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1☐Live b	tcome of pregna birth 2 Peta nant at time of d own	Ideath 3⊡	Ectopic pregnancy Other (specify)	,			te of delive	ory Day Year
rds, P	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to			ne cause of death?
al Kecord	The lay ate has page 2	Completed							24a. Was a autop: perfor 1 \(\triangle \trian	med?	prior to cor death?	psy findings available mpletion of cause of
on or vital	Physical distribution	tlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending investiga	28a. Date (Mon	Inpatient 2 of Injury th, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Worl	er: 4 Nursing	Death Check onl or J Home 5XXResid 28d. Describe h	ence 6 Oth	er (Specify	<i>t</i>)
DIVISION	after dea after dea I Director d in by the	Certification;	3 Suicide 6 Could no determin	288. Place	of Injury - At ho ng, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S City or Town	treet and Numb n, State)	er or Rura	l Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 2 Medical Ex	aminer: On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and pla pinion, death oc	ice, and due to the courred at the time, d	ause(s) and ma late and place,	and due to	ated, the cause(s)
	To th withir To th comp	W	29b. Signature and title of certifier		TOR, DIVI		29c. Licenso 2	3675	2	3.3.		Day, Year)
w	11/1		30. Name and address of person where Ross C. Donehowe				,	Center	Baltimore	e, Mary	land	21231
Ì	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9	2005 32. 8	gistrar's Signa	ture	3.15					

M			For State	State of M	aryland / Depa	artment of H			iene g. No.2 0 0 5	07935
			Registrar 1. Decedent's Name (First, Middle, Las	st)				2. Date of Death	n	3. Time of Death
	Physici			Edward	Donald	Rickter		MARCH 3	, 2005 Year	10:35 A M
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Death	
1	E A CONTINUE		6204 BROWN AVE			BALTIN	MORE CITY		N/A	
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
2	Director		218-96-5131	IXM 2□F	40 Yrs.			Dec. 8,		ryland
N)	and **	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	daryt f sho	5	Maryland N/	'A		ltimore C	ity			1 ⊠Yes 2 □ No
	289-	Director	10e. Street and Number		J	10f. Zip Code		16	0g. Citizen of What Cou	intry?
	3a or		6204 Brown Aver	nue Apt.	1A		21224		United Sta	tes
	items 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H	ispanic Origin? (Spe In, Mexican, Puerto I	city Yes or No-	14. Race - Ameri Black, White	ican Indian,
9	F o a	F	1 Never Married 2 Married	1 Tes 2 X	No	1 ☐ Yes Ž☐ No	Specify:	mount, oto.)	Specify:	White
800	72 hours natural',	d by	3 Widowed 4 Divorced	Year or Dates:	10.5	1 1 1 1 1 2				
-5	n 72	Completed	15. Decedent's Education (Specify only highest gradual)	de completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of workii f)	ng	16b. Kind of Business/Ir	laustry
12	withi lene. then	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	unds Main			Cemeterv	
<u>d</u>	Hygin Hygin ent,	e l	17. Father's Name (First, Middle, Last,)	GIO	unas_main	18. Mother's Name	(First, Middle, M	1	
Maryland 21215-0036	ss 1 and 2 should be filed within 72 ho of Health and Mental Hygiene Item 27 is marked other then "natur other treumatic svent, the Medical	To B	Gilbert Donald	Rickter			Mari	e DeBauf	fre	
ary	shou small		19a. Informant's Name/Relationship (ing Address (Street	and Number or Rura	l Route Number,	City or Town, State, Zi	p Code)
	and 2 saith n 27 i		Mrs. Rosemarie E	Bland/Sist		6 Merritt				21222
ore	or oth		20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	:a)	ate	20c. Location - City or T	own, State
Ë	Pages tment of h tent: If its jury or of		`4 □Donation 5 □ Other (Specif	y)	St. Sta		em. 3/8/2		Dundalk, M	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Euneral Servica Licer		ser 1	2. Name and Addres Ouda-Ruck	ss of Facility Funeral F	Home of	Dundalk, Ir	nc.
	402 9 9		23a. Part1. Enter the disease, or com		7	<u>922 Wise_</u>	<u>Ave. Dun</u>	dalk, Ma	aryland 21	.222 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine.		9, 000			Interval Between Onset and Death
91	/Medical	P	disease or condition resulting in death)	a	opneumonia s a consequence of):					
	Examiner			Due to (01 as	a consequence or).					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as	a consequence of):					
	cuted	Examiner	cause (Disease or injury that initiated events resulting in death) Last	C						
90,	cate be executed physician and the burial-transit		resulting in death) cast	Due to (or as	a consequence of):					
8760,	physic the b	dical		_ d					=	
9 ×	ding		IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of deli-	VALV
Вох	death certifica attending pt d for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subsection \text{Yes} 2 \subsection \text{No} \)	1 Live birth	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	<u>'</u>		Month	Day Year
P.O.	the d by the achec	nysi	9 Unknown	9□ Unknown						
	Physician: The law requires that the death certifi this certificate has been signed by the attending ral director, page 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death I	out not resulting in the t	underlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
ž	w require been sig should b		Influenza B Viru	ıs				1 □ Y€	es 200 No 3□ Pro	obably 4 Unknown
Division of Vital Records,	law re as be 2 sho	Completed						24a. Was a autops	y prior to c	topsy findings available completion of cause of
E	The ate h page	Com						1 Yes	med? death? 2 □ No 1 1 Yes	2□ No
/ita	cian: ertific	Be	25. Was case referred to medical examiner?	Hamital		O+1-	26. Place of Death			
of	Physic this c	2	Yes 2 No 27. Manner of Death	Hospital: 1 Inpati					ence 6 XOther (Spec ow injury occurred	eity) SCENE
, uc	ding f	lion	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year) Injury	Wor	yat k? Yes 2 □ No	zod. Describe no	ow injury occurred	
isi	deatl deatl ctor: y the	ficat	3 Suicide 6 Could not b		ijury - At home, farm, si tc. (Specify)				reet and Number or Ru	ral Route Number,
D.	after after Dire	Certification:	4 Homicide	building, e	tc. (Specify)			City or Town	n, State)	
	ospite hours unere ly fille		29a. Certifier 1 Certifying Pl	nysician: To the bes	t of my knowledge, dea	th occurred at the tir	me, date and place,	and due to the ca	ause(s) and manner as ate and place, and due	stated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and manner s						
	Vith To I	2	29b. Signature and title of certifier	11 . 11 mil	1	29c. Licens		2	9d. Date signed (Month) MARCH 4, 2	
			Yandy)	anau, me)				1111011 7, 2	
				completed cause of	death (Item 23a) (Type		nn Street	Baltin	more, Maryl	and 21201
	St	ite	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature	r		201611	e imiyi	CITY ALLOY
	Regist		MAR 0 9 200	Maja	Nº Spen	W .				

Ronald 05-149 AKG	1 J. Roo 95	lec	unpend item#	25 4729 ; Pein State of Mai	ryland / Dep	artment of	Health and	All Copies A Mental Hygie	re Legible.	07936
			1 - Stete Ragistrar	41	Ce	rtificate o	f Death		. No.	
-	Physic /Medi		1. Decedent's Name (First, Middle, La Ronald Joseph F	Rodecker, Jr	· .			2. Date of Death Month February	27, 2005°	3. Time of Death 7:58 AM
3	Exami	ner	4a. Facility Name (If not institution, gi Harford Memorial			1	n, or Location of Deat de Grace	th	4c. County of Deal Harford	
523	Funeral Director		5. Social Security Number 6. 219-76-5929 Usual Residence of Decedent	Sex 7. Age	(In yrs. last birthday 44 Yrs.	Months Day	ar If Under 24 Hrs ys Hours Min.		^{9. Bird} 1960 Mar	hplace (State or Foreigr punty) Yland
4)	B Maryland a-f ahow	ctor	10a. State 10b. County Maryland Harfor		10c. City, Town or L Aberde					10d. Inside City Limits 1 ☐XYes 2 ☐ No
	th with the 23a or 28	ai Director	10e. Street and Number 415 South Rogers	Street		10f. Zip Code	21001	10g	. Citizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is markad other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, I'm Medical Evanting must be notified at ance.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morried	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent o If Yes, specify Cu 1 Yes 28 N	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	i within 72 ho iene. r than "natu	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	DO NOT use reti	ne during most of wo.	rking	b. Kind of Business	
Maryland 2	uld be filed Jental Hyg rrkad otha tic avant,	To Be C	17. Father's Name (First, Middle, Last Ronald Joseph Ro		1050	ing and	18. Mother's Nar	me (First, Middle, Ma r Catherin	iden Sumame)	
	nd 2 shot aith and A 27 Is ma		19a. Informant's Name/Relationship (Eleanor C. Rodeo	**			et and Number or Ru	ural Route Number, C eet, Aberd	city or Town, State, 2	Zip Code)
Baltimore,	Pages 1 a ent of Hea nt: If itam ry or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Speci		_	matory or other p	1		c. Location - City or	
Baltii	permit. I Departm Importar any injur		21. Sign of Funeral Service Lice	name of	2: M	2. Name and Add	Funeral Ho	ome, P.A.	Baltimore	, MD 1009
•	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Cardiome			shury Roaying, such as cardiac		Ori, MID Z	Approximate Interval Between Onset and Death
60,	be executed ician and burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					*
68760,	rtificate be e ng physician as the buria	Redica	IF FEMALE.	d						
P.O. Box	that the death certific ed by the attending p detached for use as i	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnan Other (specify)	ncy		23d. Date of deli Month	very Day Year
rds, P.	w requires that the been signed by should be detact	by	Part II. Other significent conditions of	contributing to death but r	not resulting in the u	nderlying cause g	given in Part I.	23e. Did tobac	co use contribute to	
of Vital Records,	The la ate has page 2	Completed						24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
f Vit	Physicien: this certific al director,	To Be	25. Was case referred to medical examiner? 1X Yes 2 \(\subseteq \) No	Hospital: 1 ☐ Inpatient	2 KER/Outpatien	t 3 DOA		th (Check only one) ome 5 ☐ Residence	e 6 □Other (Spec	ifv)
	nding Pl ath. ir: After th		27. Manner of Death XX Student S Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Inji	ury at 'ork? □ Yes 2 □ No	28d. Describe how i		
(X) Division	i Dir	Certification:	3 Suicide 6 Could not b		- At home, farm, str Specify)	eet, factory, office	Э	28f. Location (Stree City or Town, S	t and Number or Ruitate)	ral Route Number,
C	tha Hospital hin 24 hours a tha Funaral I npletely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Example 1	sysician: To the best of r miner: On the basis of ex and manner stated	amination and/or inv	occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier	V.			nse number		Date signed (Month	
			30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)			bruary 28	
	Sta	te	31. Date filed (Month, Day, Year)	32. Ragistrar's	Signature	TIT Pel	ım street	Baltimore	, Marylan	d 21201
	Registr	ar	MAR 0 9	2005	1 1 1					

		_	State of Maryland / Dep			2005 07037							
			- State Registrar AMEND ITEM #17 PER FH G841 396 1. Decedent's Name (First, Middle, Last)	gingalgipi Dealii	Reg. No.	3, Time of Death							
1	Physicia	an		RIMSON	MARCH 7, 2	2005 Year 8:50 P M							
~	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death							
			JEWISH CONVALESCENT CENTER	BALTIMORE		BALTIMORE							
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 92 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year APR.15,19	9. Birthplace (State or Foreign Country) D.C.							
	land	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits							
	Mary In sho	tor	MD BALTIMORE	PIKESVII	LE	1 ☐ Yes 2 🔀 No							
	th the	Director	10e. Street and Number	10f. Zip Code	10g. C	10g. Citizen of What Country?							
	ath wi	ral	4613 OLD COURT ROAD #D	21208	USA								
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show important: If Item 27 is marked other than "natural", or items 23e or 28e-f show appring yor other traumatic event. The Medical Examinar must be notified at an once.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No ₩₩ I I Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE							
21215-0036	72 hou natura	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ina 16b.	Kind of Business/Industry							
12	ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		TIMODE CITY							
	filed v Hygie other t	e Co	10 WATE	ER METER READER 18. Mother's Name	e (First, Middle, Maide	_TIMORE CITY on Surname)							
Maryland	lid be lental ked o	To B	AVRAHAM RIMS	A BELLE	(UNKNOWN)								
ary	and Market Substitution	 	11.5	al Route Number, City	or Town, State, Zip Code)								
	and and marking markin	l j			ILLE, MD 21208 Location - City or Town, State								
Baltimore,	iges 1 nt of H i if Ite or otl		Manage Constitution of the control o	Da. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) SOCIETY Date 20c.									
Iţir	artmer artmer ortant injury			RTHODOX MEMORIAL 3, 22. Name and Address of Facility SOI		DUNDALK, MD							
Ba	Department Department Important in Souce			3900 REISTERSTOWN I									
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or beart failure. List only one cause on each line.			Approximate Interval Between							
	Pnysician	l n	Immediate Cause (Final disease or coldition a. Arterio sclerotto	c cardiovascular	- disease	Onset and Death Years							
	/Medical Examiner		resulting in death) Due to (or as a consequence of):										
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<u>α</u>	quires that n signed b uld be deta	Š	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		ouse contribute to the cause of death?							
I Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed			24a. Was an autopsy performed? 1 □ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No							
Vital	sicien: certific rector,	Be (25. Was case referred to medical examiner?		th (Check only one)								
of\	Phys this al di	To.	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati		ome 5 Residence								
on	19 je	tlon	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation		200. 20001120 11011 111	ary 00041104							
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	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in h	Medical C	29a. Certifier (Chack only one) Certifying Physicien: To the best of my knowledge, de 2 Medicel Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)							
) ,	To the within To the comp	M	29b. Signature and title of certifier MD	29c. License number D 35844	m	oate signed (Month, Day, Year) arch 08, 2005							
Antique to	010		30. Name and address of person who completed cause of death (Item 23a) (Typ DROGREN 5400 Old Court R		in MD	21133							
• :	Sta	ate											
	Regist	rar	31. Date filed (Month, Day, Year) MAR 0 9 2005										

			State of Maryland / Department of Health and I = State Amend Item 23a-b,pt.II,25 per me C842 4-22-05 tas	Mental Hy	giene ()5	07938
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	LILLIAN SCULLY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	March	2 200 4c. County		11:35 a ^M
	Examin	er	1415 VALENTINE AVENUE GLEN BURNIE	•	ANNE		DEL
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 89 Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da July 7	th y, Year)	9. Birthp	lace (State or Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	e Maria-fish	ctor	MARYLAND ANNE ARUNDEL GLEN BURNIE				1 ☐ Yes 2 🔯 No
	vith th	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Cour	itry?
	leath v	Funeral	1415 VALENTINE AVENUE 21061 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	necify Yes or No		.A.	an Indian,
21215-0036	within 72 hours after death with the Maryland jiene. r than "neturel", or Items 23s or 28s-f show Ite Modisal Escriptor status notified at	by	Armed Forces? 1X Never Married 2 Married 1 Yes 2XXIV 3 Widowed 4 Divorced Divorced 1 Yes 2XXIV 1 Yes 2XXIV 1 Yes 2XXIV 2 Yes 2XXIV 2 Yes 2XXIV	o Rican, etc.)		, White,	etc.
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12	e filed within II Hygiene. other than vent, It e Mas	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade HOUSEWIFE		PRIVA	n to	
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Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru				
	s 1 and 2 f Health item 27 l		Evelyn R. Haywood/Daughter 1415 Valentine Ave., 20a. Method of Disposition 20b. Place of Disposition (Name of commetter), crematory or other place)	Date Bu	rnie, Md 20c. Location -		
i E	nit. Pages partment of lortent: If it injury or o		MXBurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify), CEDAR HILL CEMETERY 03—]	12-05	GLEN BU	RNIE	, MARYLAND
Baltimore,	permit. Pages : Department of H Importent: If ite any injury or of		21. Signature of Funeral Service Literature 22. Name and Address of Facility WILLIAM C BROWN CO 1206 W NORTH AVENU	OMMUNITY JE			
j	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Complications of d			3 .	Approximate Interval Between Onset and Death
H	Examiner		Due to (or asfa consequence of): Due to (or asfa consequence of):				3years
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ó	cate be executed physician and the burial-transit		resulting in death) Last C. Due to (or as a consequence of):	1	2		
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	n certific anding p use as		IF FEMALE: 23c. If yes, outcome of pregnancy		201.0		
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 mop ris? 1		23d. Date Mor		Day Year
s, P	es that igned t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contr	bute to th	e cause of death?
ord	w requir been si should		Paraplegia complicating thoracic myelopathy;	1 []	res 2 000	3 Prob	ably 4 Unknown
Vital Records,		Completed	congestive heart failure	24a. Was autor perfo 1 Yes	med? p	ior to cor	psy findings available inpletion of cause of
N N	Physiclen: this certific ral director,	o Be	examiner?	ath Check on o		. (6:4	4
Jοι	ig Physter this	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Othe		/)
sior	Attending in death. ector: After by the funer	catio	2 Accident investigation M 1 Yes 2 No				
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1º Certifying Physician: To the best of my knowledge, death occurred at the time, date and place continuous c	, and due to the irred at the time,	cause(s) and mar date and place, a	ner as st nd due to	ated. the cause(s)
	To To To Com	Σ	29b. Signature and title of certifier (Park MD) 200 9 4		29d. Date signed	(Month)	Đāy, Year)
	+		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellic H. Gorbay and III Medium Park Drive 31. Date filed (Month, Day, Year) MAR 0 9 2005	. Gle	Burne	P CH	1,21061
	Sta Registi		MAR 0 9 2005				(

	•	1 - For State Registrar	State of Maryland		rtment of			ene2 ()	05	07939
		Decedent's Name (First, Middle, Last)	0 .				2. Date of Death		V	3. Time of Death
Physici /Medio		Uuanita R	Canders	3 -			Month	3	Year O5	10:15 PM
Examir		4a. Facility Name (If not institution, give st. Gilcrest Hospice	Center		T	or Location of Dea		4c. Count	Baltim	ore
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Day			Year)	9. Birthpla Countr	(State or Foreign
		Usual Residence of Decedent					0-21	71		
If E. 12.10.000. Itied within 72 hours after death with the Maryland Hygiene. What then "natural; or items 23e or 28e-f show ant, I've Medical Evancinat must be notified at	Funeral Director	10a. State 10b. County Baltima		r, Town or Loc)Wings	Mills				d. Inside City Limite 1 Yes 2 No
ith with the 23s or 2 ust be no	Dire	10e. Street and Number	Pun Court		10f. Zip Code	21117	10	g. Citizen of	What Countr	y?
death	nera		2. Was Decedent Eyer in U. Armed Forces?	S. 13. W	as Decedent of	Hispanic Origin?	(Specify Yes or No-		ce - America	
ite; with yielly fill of the land should be the Maryla of and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene item 27 is marked other then "netural; or items 23e or 28e-f show then traumatic event, the Medical Estatutation at the modified at	ξ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	i	Yes, specify Cr ☐ Yes 2 ▼ N	fiban, Mexican, Pue o <i>Specify:</i>	erto Arcan, etc.)	Speci	ick, White, el	ack
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withir iene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	P	O NOT USO POLI	orker		Mai	nufac	toni
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ial y allo Kile. 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, I was Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	Tof	William Jenkins				Marie				(UNKNWN
d 2 sh d 2 sh th and th and 7 ts m traum	34	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Stre	et and Number or I	Rural Route Number,	City or Town	State, Zip (Oode)
is 1 and 27 itam 27 other tr		20a. Method of Disposition			ition (Name of atory or other p	(aca)	Date Date	c. Location	- City or Tow	m, State
Page nento		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ng Pa	rK.	3+	9-05	Pattir	nore.	$m_{\rm D}$.
Dallillo permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licenses	,	22.	Name and Add	ress of Facility	17.00	eene ?	Funere	I Service
		23a Part 1 Enter the disease or complic	ations that caused the death	N Do not ente	28 Lube		<i>kandallst</i>		IVID	21133 Approximate
20.00		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	/ Do not ente	/-		ma - re			Interval Between Onset and Death
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The Colds, F.O. BOX of The law requires that the death certifule has been signed by the attending agge 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	 c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown 	death 3	Ectopic pregnar Other (specify)				ate of deliver onth C	y Day Year
that the ned by detac	by Ph	Part II. Other significant conditions cont	ributing to death but not resi	ulting in the un	derlying cause	given in Part I.	23e. Did tob	acco use con	tribute to the	cause of death?
A requires to been signed should be					-		_ 1 ☐ Ye	s 2 0 NO	3 🗌 Proba	bly 4 □Unknown
has bei	Completed						24a. Was ar		Were autop	sy findings available pletion of cause of
	Con						perform	ed? XNo	death?	2□ No
OI VILAI F Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	FD/0	•7-0. (Ther	eath (Check only one			1/20000
ding Phys	⊢	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3 DOA 28c. In	4 🔲 Nursing	Home 5 Reside 28d. Describe ho	/~	her <i>(Specify)</i> rred	Huspice
ISION ttanding death. stor: Afte	atio	1 X Natural 5 Pending 2 Accident investigation	(Month, Day rear)	Injury		vork? □Yes 2□No				
LIVIS tal or Atta s after de al Diracto ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, offic	ce	28f. Location (Sti City or Town		ber or Rural	Route Number,
To the Hospital or Atlanding Phymbin 24 hours after death. To the Funaral Director: After the completely tilled in by the funeral	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the estigation, in m	time, date and pla y opinion, death oc	ice, and due to the ca courred at the time, da	use(s) and m	anner as sta , and due to t	ted. the cause(s)
To t To t	Σ	29b. Signature and title of certifier	A. V.	0		ense number		od. Date sign		
1160	-	1 Marion	y /wy	1350 T.	100	+2 403	0	VIA	ch 4	12003
		30. Name and address of person who cor	inpleted cause of d ath (Item	6 70 (N- Ch	arles J	7. Bola	5 M	d 20	405
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture /						

Registrar

MAR 0 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** ALLEN SHEETS MAZCH CHARLES 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HALFOND UPPER CHESAPEALE NEDICAL CENTR BERAIN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** †**∑**M 2□ F Months Days Hours 220-54-9734 53 Director 1951 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other treumstic event, the Medical Examiner must be notified at Maryland Harford Edgewood 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21040 USA 3001 Ebbtide Drive 238 Completed by Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 3 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "r any injury or other treumatic event, I'm Med any injury or other treumatic event, I'm Med once. Elementary/Secondary (0-12) College (1-4or 5+) Drywall Mechanic Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fred Leonard Sheets (u/k)Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Ebbtide Drive, Edgewood, MD 21040 Toy Sheets/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Holly Hill Mem. Park 3-9-05 Baltimore, MD 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION ALUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 1 Yes 2 **B**No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending Injury 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 OME 021809 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year)

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			For State Registrar	State of Marylar	_	artment of I		nd Mental H	/giene	005	0701.1
	- · · ·		1. Decedent's Name (First, Middle, Last)					2. Date of D		Year	3. Time of Death
	Physici /Medio		Brooks N. Sipes					Februa		2005	11:40 P M
	Examir	er	4a. Fecility Name (If not institution, give s			4b. City, Town, o		Death	4c. C	ounty of Death	
			Anne Arundel Medic 5. Social Security Number 6. Sex		last hirthday)	Annap		Hrs 0 Date of B		nne Aru	
	Funeral Director		210–10–2865	M 2□F 7. Age (In yrs. 92	Yrs.	Months Days		Min. 8. Date of 8 (Month, 2)	ay, Year)	Ponn	olace (State or Foreign otry) sylvania
Ь.			Usual Residence of Decedent					10-10-	1712	гели	Syrvania
	show		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Ba-f s	cto	Maryland Anne Aru	ndel	Annapo	lis					1 ☐ Yes 2X No
	or 2	Director	10e. Street and Number			10f. Zip Code				on of What Cour	ntry?
	s 23e	eral	116 West Bay View	Drive 2. Was Decedent Ever in U	16 110 1	21403	liana air Oriain	0 /Caacite V 1		SA	and the disco
	n 72 hours after death with the Maryland "natural", or flems 23e or 28a-1 show paics Exprofred frust be notified at	by Funeral	11, Marital Status 1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No	7.5.	f Yes, specify Cub	an, Mexican, P	n? (Specity Yes or No Puerto Rican, etc.)	0- 14	I. Race - Americ Black, White,	
036	urs af		3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates: W . W .	II	1 ☐ Yes 2 🔀 No	Specify:		S	ipecify: Wh	ite
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	filed with Hygiene. other than			yrs.	Wage a	and Hour	1				vernment
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ē,	s 1 and 3 of Health item 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other pla		rive, <u>Ann</u>	20c. Loca	ation - City or To	wn, State
E O	Page ent o nt: if ry or		t Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	-	t Cemeter		5-05	Δnnar	colis, N	∕∏)
Baltimore,	perriit. Pages Depurtment of Importent: if ii any injury or o	1	21. Signature of Funeral Service License			. Name and Addre	-	George P			
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the deat							Approximate Interval Between
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	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):				,		6
Ň	certificate be executed nding physician and use as the burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):						
8760,	siciar buri	ical									
9	ificate g phy as the									T.	
Вох	seath certifica attending ph for use as th	N/	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc			23	d. Date of delive	ery
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of c		Other (specify)	у			Month	Day Year
P.0	ac of	Physician/Med	9 🗆 Unknown								
	res tha igned be det	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did			ne cause of death?
ord	w require been si should I	ted						- /	Yes 2□	No 3 Prod	ably 4 Unknown
Records,	e 2 si	Completed						24a. Wa aut	ppsy	prior to cor	psy findings available mpletion of cause of
A F	iiclen: The lav certificate has rector, page 2							1 ☐ Yes	ormed?	death?	2 No
Vital		o Be	25. Was case referred to medical examiner?	ospital:		_ Ott	200	Death (Check only			
of	ing Phys After this funeral di	 	1 Yes 2 To	28a. Date of Injury	ER/Outpatier 28b. Time of	I 3 DOA	4 [] Nursi	ng Home 5 ☐ Res 28d. Describe			γ)
on	Attending r death. sctor: After oy the fune	tion	1 Datural 5 Pending investigation	(Month, Day Year)	Injury	28c. Injui Wo M 1	rk?]Yes 2∐No				
Division	Attendii r death. ector: A by the fu	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str	eet, factory, office				Number or Rura	l Route Number,
ā	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	4 _ Homicide	building, etc. (Special	ry)			City or 1	own, State)		
	To the Hospitel within 24 hours a To the Funerel completely filled	cal	29a. Certifier Check only Check only Medical Examin	icien: To the best of my kno er: On the basis of examina	owledge, death	occurred at the ti	me, date and p	place, and due to the	cause(s) a	nd manner as si	ated.
	the H in 24 the F	ledical	one)	and manner stated.	ation and/or in			occurred at the time			
	7 × 5 × 6	Σ	29b. Signature and title of certifier	US -		29c. Licens				signed (Month,	
	/		7		ĮC.	ノリック	24	2	1ZBRI	May 28	2005
	16		30. Name and address of person who con	mpleted cause of death (Iter	m 23a) (Type,	Print)	1/-1	5./	A	NNAPO	2005 Lis Marylm 21401
			31. Date filed (Month, Day Year)	32. Registrar's Signa	1(6 f)	STENSE	Inghui	in sinte	100		21401
	Sta Regist		31. Date filed (Month, Day, Year) 9 2	005	K	franks 1					
DH	IMH 17 Rev 1/2	2001			-						

				land / Dep	artment of Health artificate of Death	and Mental Hy		07942
	Dhysis	0.5	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	aath Day Year	3. Time of Death
	Physici /Medio		Madeline Jean		Smith	March	2, 2005	7:15pm ^M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	of Death	4c. County of Dea	ith
			Kline Hospice House		Mount Air	y	Freder	ick
	Funeral Director		217-28-5673 1 M XXF 7	yrs. last birthday) 8 Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bir Min. (Month, Da NOV• 2	th 1926 Ma	nthplace (State or Foreign ountry) aryland
	pue *		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo	ocation			10d. Inside City Limits
	he Maryli 8a-f eho otified a	ector	Maryland Frederick	Frederi	ck			1 XYes 2 □ No
	ath with t	ral Dir	10e. Street and Number 610 Taney Avenue		10f. Zip Code 21702		10g. Citizen of What C	ountry?
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f ehow or other traumatic event, the Medical Exambra must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve. Armed Forces? 1 Yes, Give Year or Dates:		Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2 X No Specify:			
21215-0036	vithin 72 ho ne. han "natur nedicel	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +5	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Business	
land 21	ould be filed with Mental Hygiene. Brked other than	To Be Col	17. Father's Name (First, Middle, Last) William Elmer Buhrman	50		er's Name (First, Middle Catherine Ma		n
Maryland	1 and 2 should I Health and Meni tem 27 is marke	-	19a. Informant's Name/Relationship (Type, Print) Jack G. Smith, husband	19b. Maili 610	ng Address (Street and Number Paney Ave., Fr	er or Rural Route Numb rederick, Ma	er, City or Town, State, aryland 217	Zip Code) 02
Baltimore,	nit. Pages 1 s artment of He ortent: If Item Injury or othe		20a. Method of Disposition 1	Nob. Place of Dispo cemetery, crea Mount Hope	osition (Name of matory or other place) Cerretery March	5, 2005	Woodsboro,	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licenship MO 23a. Part 1. Enter the disease, or complications that caused the	0255	2. Name and Address of Facili Keeney & Basf 06 East Church	ord P.A. Fu St. Freder	meral Home	and 21701
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a co	lym	er the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
68760,	deeth certificate be executed as eattending physician and ad for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b	insequence off.				
О. Вох	at the deeth certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
rds, P	signed d be de	þ	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause given in Part I	. 23e. Did t	obacco use contribute to	o the cause of death?
I Record		Completed	Renal Concer			24a. Was autoj perfo	osy prior to death?	utopsy findings available completion of cause of
on of Vital	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2	2 ER/Outpatier 28b. Time o	nt 3□ DOA Other: 4□ Nu	28d. Describe	one) dence 6 Other (Spechow injury occurred	icify) H
Division	al or Attendi safter death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	At home, farm, str specify)	eet, factory, office	28f. Location (a City or Tox	Street and Number or R wn, State)	ural Route Number,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by i	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of m 2 Medical Examiner: On the basis of example and manner stated	y knowledge, deat imination and/or in	n occurred at the time, date an vestigation, in my opinion, dea	d place, and due to the the courred at the time.	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	th, Day, Year)
•			1 pann ()	(A) 4:	D 16428		March 3, 2	005
	10		30. Name and address of/person who completed cause of death Casper E. Cline III, M.D.,			, Frederic	k, MD 21701	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2005	Signature	K)			

			State of Maryland / Department of Health ar 1- State Registrar Certificate of Death		ental Hygie	_	5 0791.2
	Physici		Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Ye	3. Time of Death
	/Media		Violet Sarah Spagnolo		March 4		5:00 P M
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of the street and number is a street and number.	Death		4c. County of E	
			Stella Maris 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4 Hrs I o	Date of Righ	Baltir	
	Funeral Director		1 M 2 T F Wonths Days Hours	Min.	B. Date of Birth (Month, Day, Y	(ear)	Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent	11	EU. 2,	1320	Marytanu
	arylan show	B	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	8a-1	cto	MD Baltimore Lutherville				1 □ Yes 2X No
	with the	Ö	10e. Street and Number 10f. Zip Code		100	Citizen of Wha	
	eath r 23	erai	1705 Greenspring Drive 21093 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n2 (Speci	fy Yes or No-		ed States American Indian.
,,	fter d r iten	Fun	Armed Forces? If Yes, specify Cuban, Mexican, I	Puerto Ri	can, etc.)		Vhite, etc.
036	ral', o	b	3√√Widowed 4 □ Divorced If Yes, Give Year or Dates:			Specify:	White
7,	within 72 hours after death with the Maryland ene. Then "natural" or Items 23a or 28a-f ehow he Madral Examiner must be notified at	Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of	of working	16	6b. Kind of Busin	ess/Industry
5	within ne. han	ldm	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)				_
Ġ	be filed vatal Hygie of other ts svent, the	ပိ	B Lab Tech 17. Father's Name (First, Middle, Last) 18. Mother's	s Name (First, Middle, Ma	Noxell	Corp.
<i>P . M .</i> Marviand 21215-0036	d be ental ced o	To Be	l library and the state of the	garet		calf	
M. N.	should to Ment warked	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of				te, Zip Code)
	alth a		Frank P. Spagnolo/son 1308 McPhereson Cou	ırt	Lutherv	ille, MD	21093
5:00	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic svent, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	13/05	9/2005 ²⁰	c. Location - City	or Town, State
5	Pages ment of ant: If it ury or o		'4 Donation 5 Other (Specify) Dulaney Valley Mem. Grdr	ns.		Timonium	n, MD
+	permit. Departitimport		21. Signature of Funeral Service Licensee 22. Name and Address of Facility				
			Julio Coll Stephen Coster 1050 York Road				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	ardiac or r	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				hours
	Examiner		Due to (or as a consequenca of):				
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
V	ate be executed hysician and the burial-transit	Examiner	Cause. Enter underrying Cause (Disease or injury that initiated events c.				
C	ie be executed ysician and e burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
005 68760	ate by	dical	d				
200	w requires that the death certificate been signed by the attending phashould be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
4,	atten for us	cian	in the past 12 months?			23d. Date of Month	delivery Day Year
	the d y the iched	ıysi	1 Yes 2 No 9 Unknown 9 Unknown				
MARCH	s that ned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did toba	cco use contribut	e to the cause of death?
MA	quire en sig ruld b	ed t	Urinary Tract Infection	_	1 🗆 Yes	210 No 3	Probably 4 Unknown
O S	law re	piet			24a. Was an	24b. Were	autopsy findings available to completion of cause of
SPAGNOLO MAI	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed			autopsy performe 1 Yes 2	d? deatl	to completion of cause of h? Yes 2/2 No
AG.	cian: ertific ector,	Be (Check only one)		
SF	hysi this c	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursi				Specify)
	Jing F	Certification;	27. Manner of Death 1 2Natural 5 Pending (Month, Day Year) 2 Acceptant investigation 28a. Date of Injury (28b. Time of Injury Work? 1 Yes 2 No		d. Describe how	injury occurred	
VIOLET	Attending or death. ector: After by the fune	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office		f. Location (Stree	et and Number o	r Rural Route Number,
	after Dire d in b	erti	4 Homicide building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	aic	29a. Certifier 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and p	place, and	d due to the caus	se(s) and manne	r as stated.
	the Ho hin 24 the Fu	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred	at the time, date	and place, and	due to the cause(s)
	Withi Tot	Σ	29b. Signature and title of certifier 29c. License number	7111		. Date signed (M	7 1/
			mestine and the MID DOS	146		Vlarch	12005
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD	m+ 14	(A) T 1734	WD 27000	
	Sta	ite.	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	T.T IA	ONTUM, I	MD 21093	
	Regist		MAR 0 9 2005 Brown & County				

DHMH 17 Rev 1/2001

			1 - For State Registrar			/ Depa	artment of F	lealth a		ental Hygi	•	ne. n a	07011
			Decedent's Name (First, Middle, I	.ast)			tinodio or	Dodin	1	2. Date of Death	-	للبل	3. Time of Death
	Physici		Madeleir	ne D	1.	Slea	ar			March 7	, ^{Day} 2005	Year	5:53 A M
	/Medic Examin		4a. Facility Name (If not institution, g			0100	4b. City, Town, o	r Location of		110.01.7	4c. County of	of Death	0.00 K
	LAdillii	CI	6006 Roland Av				Balti	more					
	Funeral			Sex 7. Ad	ge (In yrs. last	birthday)	If Under 1 Year	If Under 2	24 Hrs.	B. Date of Birth	Vonel	9. Birth	place (State or Foreign
	Director		213-14-3490	10M 20 F	90	Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day, March 24	,1914	Ma	ryland
	p ,		Usual Residence of Decedent		10c. City, T					-			104 1-14 00 11-0-
	anylau show	_	10a. State 10b. County										10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Me M	Directo	Maryland Baltin	ore	Ba	ltim				1 40	- 000		
	with the party	급	10e. Street and Number				10f, Zip Code			10	g. Citizen of W		ntry!
	eath se 23	erai	6006 Roland Ave	12. Was Decedent	Ever in U.S.	13	21210		nin? (Spec	ify Vas or No-			can Indian,
	ter d	Funerai	1 Never Married 2 Married	Armed Forces	?.		Was Decedent of H f Yes, specify Cuba	an, Mexican,	Puerto R	ican, etc.)		, White,	
36	urs af		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐ No	Specify:			Specify:	Wh	ite
Ö	within 72 hours after death with the Maryland ene. than "natural" or itema 28a or 28a-f show the Modical Examiner must be notified at	Completed by	15. Decedent's (Specify only highest of	Education	1	6a. Dece	dent's Usual Occup	ation	at wantin	1	6b. Kind of Bus		
215	e. en "r	ıpie	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	d) most	OF WORKING	,			
7	filed wi Hygien other th ent, the	Son	12				Homemaker	_			Own 1		
Maryland 21215-0036	be filk ital Hy id oth	Be	17. Father's Name (First, Middle, La	st)				18. Mother	r's Name (First, Middle, M	aiden Sumame	9)	
<u>yla</u>		ပို	John J.	Duggan					ary	Dugo			
Jar	2 sh and Is m raum		19a. Informant's Name/Relationship				ng Address (Street				4.54%		
	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		Sharon Slear 20a. Method of Disposition	Daughter			Amberly Wante of	lay	Balti	more, M	laryland		
٥	Pages nent of h int: if ite		1 YBurial 2 Cremation 3	☐Removal from State	New come	Cath	natory or other place edra l	ce)					
Baltimore,	it. Pa ntmer rtant njury		'4 ☐ Donation 5 ☐ Other (Spe 21. S mate: of heral Scryin Lic			Ce	metery 2. Name and Addre	- 3	-11-2		altimo		Maryland
Ba	permit. Pages Department of Important: If if any injury or o		4-3(1)	•					Nuc				Home, Inc.
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death. [Do not ent	1050 Yor	K KUd	cardiac or	Towson,	Marylo	חמ	Approximate
l.			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each I	line.		2.0 0.4	1 1 1 =	P				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		s a consequen		near ac					-	Zyears
В	Examiner				o a conduction	00 017.							V
٠,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liscase or in jury	b. Due to (or as	s a consequen	ce of):							
V	cuted nd ransif	Examiner	that initiated events	с								-	
760,	ate be executed hysician and the burial-transit	Ä	resulting in death) Last	Due to (or as	s a consequen	ce of):							
876	cate b ohysic the b	dicai		d								-	
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy	,							
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	ath 3[Ectopic pregnancy Other (specify)	/			23d. Date Mon		ery Day Year
P.O.	the de the ched	isic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	it time of doubt	. 30	Journal (appeary)						
	that ned b	by Pt	Part II. Dther significant condition	contributing to death t	but not resultin	ng in the u	nderlying cause giv	en in Part I.		23e. Did toba	cco use contri	bute to t	he cause of death?
202	quires n sign uld bu		Seizure d	sorder						1 ☐ Yes	2 No	3 🗌 Prol	oably 4 Unknown
000	sw requir s been si 2 should	Completed	O							24a. Was an	24b. W	ere auto	ppsy findings available
æ	The ta	mo l		•						autopsy perform	ed? de	eath?	mpletion of cause of 2 No
ta	rtifica	Be C	25. Was case referred to medical					26. Place	of Death (Check only one			
>	Physician: r this certifica ral director, I	To	examiner? 1 □ Yes 2 No	Hospital: 1 Inpati	ient 2 ER	/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nur	rsing Hom	e 5 Resider	ice 6 Othe	r (Speci	(y)
0	ng Pt ter th neral	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28 ay Year)	b. Time o Injury				d. Describe how	v injury occurre	d	
Sio	Attending ir death. ector: After by the fune	catio	2 Accident investigation	ion			M 1 🗆	Yes 2□N	_				
Division of Vital Records,	l or Att atter d Direct I in by	Certification:	3 Suicide 6 Could no 4 Homicide determin	. a 286. Place of In	ijury - At home tc. <i>(Specily)</i>	, farm, str	eet, factory, office		28	If. Location (Stre City or Town,	eet and Numbe State)	r or Run	al Route Number,
	Hospital or 24 hours atte Funeral Dir tely filled in I		29a. Certifier X Certifying	Physician: To the best	t of my knowle	dae dest	n occurred at the tre	no data and	f place, an	d due to the cau	sco/o) and mad		tated
	24 hc 24 hc e Fun	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner st	of examination	and/or in	vestigation, in my o	pinion, deat	h occurred	d at the time, da	te and place, a	nd due t	o the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier		· · · · · · · · · · · · · · · · · · ·		29c. Licens	e number		29	d. Date signed	1	
}			· Caul	avades			102	7209	1		3/1	120	0.5
			30. Name and address of person wh	no completed cause of	death (Item 23	Ba) (Type,	Print) Pati	laa	Va	Vacel	, mi		
	10		10155 Hall	J Kays	UIK	20	10 lut	herv	1110	Me	0 6	109	3
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 9		trar's Signature		in the						
	riegisti	G)		LUUJ LANGE	var jar								

			1 - For State Registrar	State of Maryl		artment of H			jiene leg. No.	00	5_0	79	45
	Physici	an	1. Decedent's Name (First, Middle, Last)		L. Sojk	a. Sr.		2. Date of Dea Month	Day	Ye	0.0	Time of D	
	/Medic Examin		4a. Facility Name (If not institution, give s				or Location of Deat	MARCIT	06 4c. C	ounty of E			
	×		GOOD SAMARITAN	HOSPIT	AL	BALTI	MOR E			N/A			
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, Year)		Birthplace Country)	(State or	Foreign
	Director		215-16-1771 Usual Residence of Decedent	83	Yrs.			Aug. 25	192	1	Mary	land	
	yland now		10a. State 10b. County	10c	. City, Town or Lo	ocation					10d. I	nside City	Limits
	e Mar Hiffed	ctor	Maryland Ba	ltimore		100	Dundal1	k				1 ☐ Yes 2	2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of Wha	t Country?		
	72 hours after death with the Maryland natural", or Itams 23a or 28e-f show itsal Esaminat must be inclifted at		2710 Gray Manor	Court 12. Was Decedent Ever i	- 110	Man Danidan at 1		21222			Stat		
	fter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2X No				Specify Yes or No- to Rican, etc.)	14		American II Vhite, etc.	idian,	
936	ral', o	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		S	pecify:	Whi	te	
21215-0036	i within 72 hours after death with the Marylan liene. I than "natural", or Itams 23a or 28e-1 show The Medical Examinational Lemplified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup	during most of wa	orking	16b. Kind	of Busin	ess/Industr	у	
121	within lene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d)						
d 2	Tyg Than		12 Years 17. Father's Name (First, Middle, Last)		As	sembler	18. Mother's Na	me (First, Middle,			Marri	eta	
an	D 0 0	To Be	Joseph Sojka				·	Tina Schu	ıltz				
Maryland	d 2 should be f th and Mental P 7 is markad of traumatic eva		19a. Informant's Name/Relationship (Ty	•		_		ural Route Numbe				*	
	D = 2.1		Mr. Paul E. Sojk				Manor Cou	urt Dund					222
Baltimore,	ges t of M if		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R	emoval from State	-	matory`or other pla	1	Date			or Town,		
薑			↓ □ Donation 5 □ Other (Specify)21. Sign = Ure of Funeral Service License	3/10/200)5 D	unda:	lk, M	aryla	and				
Ba	permit. Departr Importa any inji		De C		of Dundalk, Inc. , Maryland 21222 ry arrest. Approximate								
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.			ng, such as cardia	ic or respiratory ari	rest,		Inte	proximate erval Betwe set and De	een eath
橿	Pnysician /Medical	de la	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con		RY AR	CREST						
	Examiner			SEPSIS	isaquarica or,								
	- E	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):								
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	PNEUMON									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit		Todaling in South, East	Due to (or as a con	isequence or):								
687	ficate physis the	Physician/Medical		d.			-1						
Вох	leath certific attending pl	In/M	23b. Was decedent pregnant	3c. If yes, outcome of pre		Dectopic pregnanc			23	d. Date of	delivery		
	e deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time 9□Unknown		Other (specify)	y 			Month	Day	Ye	ar
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions cor		resulting in the u	andorhina causa an	on in Part I	23e. Did to	pacco use	e contribu	to to the co	use of de	ath?
ds,	signe d be c	d by	RESPIRATORY	FAILUR		indenying cause giv	ren in Fanti.		es 2		Probably		
Records,	w requir been si should	lete	CONGESTIVE F			2 5		24a. Was a			e autopsy f	findings av	vailable
Re	The lav	Completed by						autop		prior	to comple	tion of cau	use of
Vital		Be C	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only or			res 22	,NO	
of V	S S	To	examiner? 1 ☐ Yes 2 🛣 No	fospital: 1 KInpatient	2 ER/Outpatie	nt 3 DOA Ott	ner: 4 ☐ Nursing I	Home 5□ Resid	ence 6[Other (Specify)		
n o		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of injury	Wo	rk?	28d. Describe h	ow injury	occurred			
Division	tan leat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home farm et		Yes 2 □ No	28f. Location (S	treet and	Number	r Dum I Do	uto Numb	ar.
Di∨	al or Attandation after death	Certification;	4 Homicide determined	building, etc. (Sp.	pecify)	reet, ractory, onice		City or Tow		i i i i i i i i i i i i i i i i i i i	riurairio	216 140/1106	51,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	edical C		sician: To the best of my ner: On the basis of exar and manner stated.									
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier			29c. Licens					fonth, Day,		
			MUSTUTE	MD		RES	5-000	D /	MAR	CH,	06,	200	05
	3		30. Name and address of person who co				CHADD	E, BAL	TIME	v <	MD	212	20
			M.E. NOTTIDGE,			E'N Dom	L E VIII D	٥, ١٩٠		, ,	4	; 4-	. 77
	Sta Regist		31. Date file WAR. Ov. 9°°2005	32. Registrar's S	ABON	W							

JOSEPH

507/c4,

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	lealth and N Death		iene () () 5	07946
	-		Decedent's Name (First, Middle, Last))				2. Date of Deat Month		3. Time of Death
	Physicia /Medic		THELMA	Κ.		SIM	ON	MARCH 6	5, 2005 Year	2:00 P M
	1 Examin		4e. Fecility Name (If not institution, give LORIEN NURSING	HOME			COLUMB 1	Α	4c. County of Death	HOWARD
	Funeral		5. Social Security Number 6. Se	TM 000	s. last birthday) Q1 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEP.17,	Year) 9. Birth	place (State or Foreign intry)
	Director		139-16-3957 Usuel Residence of Decedent	Χ	81 Yrs.			SEP.17,	,1923	NJ
	/land		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Man	į	MD HOV	VARD	COLU	JMBIA				1 ☐ Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	23a (6264 WILD SWAN V	VAY			21044			USA
36	be filed within 72 hours after death with the Maryland all hygiene. Hygiene dither than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow avant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	ispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White Specify:	
8	2 hou		15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/Ir	ndustry
215	hin 72	ple	(Specify only highest grade Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wor. d)	king		
21	giene giene er the	Completed	12		B00k	KEEPER			ADVERTISING	G AGENCY
Maryland 21215-0036	2 should be filed and Mental Hygi Is marked other sumatic avant,	To Be (17. Father's Name (First, Middle, Last) DAVE	KL	IRTZMAN		JENNIE	ne (First, Middle, I		HORTCOVER
	alth a		19a. Informant's Name/Relationship (7) DENNIS SIMON / S	ype, Print) SON	1	ng Address (Street)			City or Town, State, Zi	
ē,	of Health Item 27 other tr		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City or T	own, State
Ē	Peges nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 🂢 F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State		HAM CEM.		07/2005	UNION, NJ	
Baltimore,	permit. Peges Department of Importent: If it any injury or o		21. Signature of Funeral Service Licens	Cetter		2. Name and Addres	3(SON & BROS. PIKESVILLE.	
r	5		23a. Fart1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de ne cause on each line.	ath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
-4	Physician		Immediate Cause (Final disease or condition	aLl	ING MASS	5				011301 4110 50441
4	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
le:		-	Sequentially list conditions,	b. Due to (or as a cons	equence of):					
	nsit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
<u>`</u>	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):				1	_
8760,	e law requires that the death certificate be executed has been signed by the attending physicien and ge 2 should be detached for use as the builal-transit	dical		d						
9	ng ph as th	0	IF FEMALE:				-			
Вох	death certifica attending ph of for use as t	hysiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1☐Live birth 2☐Fe	ital death 3	Ectopic pregnancy	,		23d. Date of deliving Month	rery Day Year
<u>o</u> .	the all	sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)				,
۵.	ires that the de signed by the a t be detached i	Ω.	Part II. Other significant conditions co	ntributing to death but not n	esulting in the u	inderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ds,	uires signi ld be	d by		-	-	, ,		1 🗆 Y	es 2□No 3□Pro	babiy 4 Nunknown
200	w requir been si should	lete						24a. Was a	n 24b. Were aut	opsy findings available
of Vital Record	Tie lav	ompleted						autops	med? prior to co	ompletion of cause of
ta	certificate	e C	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·			26. Place of Dea	th (Check only on	X	20.10
Σ	8 S S	To B	examiner? 1 D Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	er: 4 💢 Nursing H	ome 5 Reside	ence 6 Other (Speci	ify)
0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	28d. Describe ho	ow injury occurred	
Sio	Attending r death. actor: After by the fune	catic	2 Accident investigation				Yes 2 □ No			
Division	i Sirie	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st cify)	reet, factory, office		28f. Location (Si City or Town	treet and Number or Rui n, State)	al Route Number,
	Hospita 14 hours Funeral tely fillec	edical C		vsician: To the best of my k inar: On the basis of exami and manner stated.						
	To the Hos within 24 has To the Fun completely	Med	29b Signature and title of certifier	A STATE OF STATE OF		29c. Licens	e number	2	9d. Date signed (Month	. Day, Year)
	- 5- 7		A. A. CO.A.			DOC	060566	9 5	MARCH 7	. 2005
1	11		30. Name and address of person who c	ompleted eause of death (II	em 23a) (Type,		2 3 00			, 3
						K RIVER N	ECK ROAD	BALT	IMORE, MD 2	1221
200	Sta Regist		31. Date filed (Month, Day, Year) MAR (1.9.20	32 Registrar's Sig		este				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Month Year **Physician** March 6, 8:17am M Charles L. Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 1921 Massachusetts Director June 10. 166-18-0414 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, It's Medical Examilier must be notified an once. 1 ☐ Yes 2 XNo Funeral Director Baltimore <u>Timonium</u> Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12101 Tullamore Court #302 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Thompson, Charles Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by WWII 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Radio & Television Sports Broadcaster 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Lloyd S. Thompson Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty Thompson/Wife 12101 Tullamore Ct. #302 Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 3/10/05 ' 4 □ Donation 5 □ Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24/1001 /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician al s the burial-t Physician/Medical attending to IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2E No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\tau \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred After t 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident within 24 hours after dea To the Funeral Directo completely filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖯 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00043489 deline

State Registrar

DHMH 17 Rev 1/2001

Box 68760,

P.O.

Division of Vital Records,

Brian 31. Date filed (Month, Day, Year) MAR 09 6569 N. Charles St. Scire 601 Touser Md. 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		٠	For State Registrar	State of Ma	ıryland /		artment of H			giene Reg. No.	05 07948
			Decedent's Name (First, Middle,)	Last)					2. Date of De	ath	3. Time of Death
	Physici /Medic		SOPHIE		TR	UE	TT		MAACIT	Day -	2005 3:55 P M
7	Examir		4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, or	Location of De			ty of Death
			NORTHWEST &	tos FITAL			RANDI	ALLS TO	البرلين	BE	ALTIMORE
	Funeral		5. Social Security Number 6	. Sex 7. Age	(In yrs. last b	birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th	Birthplace (State or Foreign Country)
	Director		220-12-4841	1 M 2 F	78	Yrs.	Months Days	Hours Mi	" (03713	1926	Delaware
	p ,		Usual Residence of Decedent	-	10.00						
	aryla shov	_	10a. State 10b. County		10c. City, To						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-f	ctc	MD Baltin	nore	Balt	imor	-				
	ath with the Marylan 23s or 28s-f show	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?
	s 23s	Funeral I	2920 Georgia Ave					21227		USA	
	er de Item	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Ra Bla	ce - American Indian, ack, White, etc.
36	ours after deat ral', or Items ? Examiner mu	by F	1 ☐ Never Married 2 ☐ Married 3 🎖 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XN If Yes, Give Year or Dates:	0	1	☐Yes 2∏ No	Specify:		Speci	White
8	within 72 hours after death with the Maryland ene. Than "natural" or flems 23e or 28e-f show he Madical Examiner must be notified at		15. Decedent's		16	a Deced	ent's Usual Occupa	ation			
15	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work done of NOT use retired	furing most of w	vorking	100. Killd of E	Business/Industry
12		E O	Elementary/Secondary (0-12)	College (1-4or 5- n/a			aker			OI II	n_home
D	H S H	a)	17. Father's Name (First, Middle, La	st)				18. Mother's N	lame (First, Middle,		
	Q = D =	ToB	Francis Rogowski					Pe	earl Olsz	ewski	
ary	2 should and Men Is marks sumatic		19a. Informant's Name/Relationship	(Type, Print)	19	9b. Mailin	g Address (Street a		Rural Route Numbe		n, State, Zip Code)
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Timothy Truett/	son					Baltimor		
ē,	s 1 a of Hei item othe		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other place	1	Date		- City or Town, State
Ë	Pages nent of int: If it		★Burial 2 □ Cremation 3 A□Donation 5 □ Other (Spe A□Donation 5 □ Other (Spe B□Donation 5 □ Oth				dge Mem.	1	3/8/2005	Elkric	lge, MD
	그 토론증 .		21. Signature of Funeral Service Lice]					ufman F	uneral Home at
m	Depa Impo any i		MKK. Ho	ilman	_	72	eadowrid 50 Washir	le Memoi	rial Park	ridae,	uneral Home at MD 21075
			23a. Part1. Enter the disease, or co shock, or hear failure. List or	mplications that caused	the death. Do						Approximate
	Physician		Immediate Cause (Final								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a			RUNIC OB	STRUCT	IVE AVEMO	WHIT P	13 E m e
М	Examiner										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence						
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events	C							
o,	an ar rial-t		resulting in death) Last	Due to (or as a	consequence	e of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical		d							
99	ntifica ng ph as th	0	IS SERVALS.								
Вох	eath certific attending p	l/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		th 3⊡	Ectopic pregnancy			23d. Da	ate of delivery
Э. Е	o dea he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown			Other (specify)			M	onth Day Year
P.O	that the de led by the detached	h	9 ☐ Unknown								
Ś	es th igned	by	Part fl. Other significant conditions	contributing to death bu	t not resulting	in the un	derlying cause give	n in Part I.			tribute to the cause of death?
ord	v requir been s should	ted							1 U Y	'es 2□No	3 ☐ Probably 4 ☐ Unknown
Records,	lawr as be	Completed							24a. Was autop		Were autopsy findings available prior to completion of cause of
		Con							perfo	rmed? 2 No	death?
Vital	ilcian: The certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of D	eath (Check only o		
Mana	d is	2	1 Yes 2 No	Hospitaf: 1 Impatier	nt 2 ER/C	Outpatient	3□ DOA Othe	4 Nursing	Home 5 Resid	tence 6 Ott	her (Specify)
0	ng Ph fter th meral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury occur	rred
Sio	eath. or: A	cati	2 Accident investigat				M 1 □ Y	'es 2 □No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, i . <i>(Specify)</i>	farm, stre	et, factory, office		28f. Location (S City or Ton	Street and Numi vn, State)	ber or Rural Route Number,
	urs a oral D										
	Hosy 24 ho Fune stely fi	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of aminer: On the basis of and manner state	examination a	ge, death and/or inv	occurred at the tim estigation, in my op	e, date and pla inion, death oc	ce, and due to the c curred at the time, o	cause(s) and m date and place,	anner as stated. and due to the cause(s)
	To the Hospital or Attending Ph within 24 hours atten death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of comilar	and maillier stat	···		29c. License	number		29d. Date signe	od (Month, Day, Year)
	2/1				M.	· >	DY	1722	_	1/ 4// 11	4 2005
	111		30. Name and address of person wh	o completed cause of de	ath (Item 23a)) (Type, F	Print)			,	
	(U		31. Date filed (Month, Day, Year) MAR 0 9 20	N 5602 BA	LTIMORE	NA	TIONAL PIK	E #603	BALTIMO	RE MO	21228
	Sta	te	31. Date filed (Month, Day, Year)	2. Registra	r's Signature	1	d.	.,	,	- /	
	Registr	ar	MAR 0 9 20	105 Jan	# 1	6984					

			1 - For State of Maryl		artment of H			giene 005	07949
			Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death
	Physici /Medic		Evelyn R. Truma	n			Feb. 2	Day Year 8. 2005	10:40p M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of D		4c. County of Dea	ath
			Rossville Manor Care		Balti	more		Baltime	ore
	Funeral		040 05 000- 104 005	yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Birt Min. (Month, Da	h 9. Bi	rthplace (State or Foreign ountry)
L	Director			5 Yrs.	Bays	Tiodis	Jan23,		A
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	naction				10d. Inside City Limits
	aho	5	MD Baltimore	. Oily, TOWN OF EL					1 ☐ Yes 2 🛣 No
	Ba-f	Director			Essex				
	with t	ä	10e. Street and Number 1141 Foxwood Lane		10f. Zip Code			10g. Citizen of What C	ountry?
	s 23	Funeral		- 110	212		0.40	USA	
	ltam	i,	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married	n U.S. 13.	If Yes, specify Cuba	n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	- 14. Race - Am Black, Wh	
36	I', or	by F	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specif W h	te
Ş	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f ahow ant, the Madical Examiner mast to motified at	ed	15. Decedent's Education	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Business	
15	in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of	working	100.11.11.001.001.001	a made by
212	iene iene r tha	E O	Elementary/Secondary (0-12) College (1-4or 5+)		Waitress	5		Roma's	
ᅙ	Hyg othe ent,	a	17. Father's Name (First, Middle, Last)				Name (First, Middle,		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Menthed thylpens is and Menthed thylpens is marked to the typens "natural; or itams 23a or 28a-1 ahow aumatic event, the Maritical Examiner mast be nutilitied at	To B	Bower Shields			Mah	ol Domas		
3	should ind Men s marke umatic		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number of	el Ramse r Rural Route Numbe	Y or, City or Town, State,	Zip Code)
	다 C 로 다		Larry Truman /son	114	1 Foxwor	nd Lar	ne Balti	more MD	
ē,	ss 1 an of Heal Item 2	,	20a. Method of Disposition 20	b. Place of Dispo	osition (Name of matory or other place		Date	20c. Location - City of	Town, State
Ê	Pages nent of I int: If Its iry or o		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	JakLawn	Cemeter	ÿ 3,	/4/05	Baltimor	e MD
Baltimore,			21. Signature of Funeral Service Licenses)	2	2. Name and Addres				
B	permit. Departr Imports any inju		A Terry Com Ul	1			Connelly	FuneralH	omeofEssex
			23a. Part . Enter the disease, o complications that caused the c shock, or heart failure. List only one cause on each line.	Jeath. Do not en	ter the mode of dying	g, such as car	diac or respiratory ar	more MD	Approximate
			Immediate Cauce /Final	. 1					Interval Between Onset and Death
	Physician /Medical		disease or condition a.		ve kol	remuti	1 13 chas	mes	
	Examiner		Due to (or as a con	0.0	val F	ail.	ischae		- 3
		- a	Sequentially list conditions, fi any, leading to immediate Due to (or as a con		7 400	man			
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	visale					
	al-tra	xa	that initiated events resulting in death) Last C. Due to (or as a con						
8760	cate be executed obysician and the burial-transit	dicall	a Hyrrer	tensun					
89	flicate g phys	edic	w						
Вох	The law requires that the death certifics the has been signed by the attending phage 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre					23d. Date of de	liverv
m	death atte	cla	in the past 12 months? 1 □ Yes 2 □ No 1 □ Yes 2 □ No		□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	at the de by the a tached	hys	9 ☐ Unknown 9☐ Unknown						
<u>.</u> ص	res that igned b be deta	by P	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	n in Part !.	23e. Did to	bacco use contribute t	the cause of death?
g	quire; n sig nd bu		Drainie				1 🗆 Y	es 2. Mo 3. P	robably 4 Unknown
00	w requires been si should I	lete					24a. Was	an 24b. Were a	utopsy findings available
Re	The lav	Completed					autop perfor	sy prior to death?	completion of cause of
a			25. Was case referred to medical			00 Plana - (1		2 ☐ No 1 ☐ Yes	2 □ No
Division of Vital Records,	Attending Physician: r death. sctor: After this certifice by the funeral director, i	o Be	examiner? Hospital:	2 ER/Outpatier	othe		Death (Check only or	ne) ence 6 □Other(Spe	
o	Phy ir this aral d	\vdash	27. Manner of Death 28a. Date of Injury	28b. Time of				ow injury occurred	icity)
on	ding f h. After funer	tlor	1 ☑Natural 5 ☐ Pending (Month, Day Yea 2 ☐ Accident investigation	r) Injury	Work	:? /es 2 □ No			
/ISI	after death after death Director: in by the	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - /	At home, farm, str	reet, factory, office			treet and Number or R	ural Route Number,
	after after Dire	Certification:	4 Homicide building, etc. (Sp	ecify)			City or Tow	m, State)	
	To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deat	h occurred at the tim	e, date and pl	ace, and due to the d	ause(s) and manner a	s stated.
	e Ho 24 t e Fu letely	edical	(Check only 2 Medical Examiner: On the basis of examiner) and manner stated.	nination and/or in	vestigation, in my op	inion, death o	ccurred at the time, o	late and place, and du	to the cause(s)
	ro th Withir Fo th	Me	29b. Signature and title of certifier		29c. License	number	4	29d. Date signed (Moni	h, Day, Year)
)			No No		DE	31464		3/2/05	
	1		30. Name and address of person who completed cause of death	(Item 23a) (Type	Print)			-	
	9		SHOAII3 A HADAMI 821	N. E.	for St	Int	2 30 8 1	salt my	21201
	Sta	te	31 Date filed (Month Day Year) 32 Beginnar's S	ignature A	Acardo 3				
	Registr		MAR 0 9 2005	But with the	C. Service				

			ricasc	State of Marylan	d / Department of	£	•	_	07070
			1 - For State Registrar	Otato or marytan	Certificate of		Reg. No	4000	0/950
			Decedent's Name (First, Middle, La		,		te of Death		3. Time of Death
	Physici /Medic		Linda	V	ines	M	ech 5	2005	17:54 M
e de	Examin		4a. Facility Name (If not institution, give	re street and number)	4b. City Town,	or Location of Death	40	. County of Death	•
			THE JOHNS &	OPKINS TRSY	last birthday) 1 Under 1 Year	frakka If Under 24 Hrs. 8, Da	A 4 Dint	NIA	
т	Funeral Director			Sex 7. Age (In yrs. 1 ☐ M 2 🔀 F	Yrs. Months Days	Hours Min. (M	te of Birth onth, Day, Year) いれずろ,19	9. Birthp	place (State or Foreign htry)
	_		Usual Residence of Decedent	, 0		JAN	CHR DIT	2/ 1/1	CONTA
	rylan thow	_	10a. State 10b. County		y, Town or Location	- 1		1	10d. Inside City Limits
	8a-f	cto	MARYLAND NIA	BF	ALTIMORE	CITY			1 Yes 2 No
	with the	Dire	1301 GREGOT	2 1/11/	10f. Zip Code	201		tizen of What Cour	ntry?
	eath is 23	Funeral Director	1301 GREGOT	12. Was Decedent Ever in U.	S 13 Was Decedent of	Hispanic Origin? (Specify Y		14. Race - Americ	ean Indian
"	r iten	T.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 M No		Hispanic Origin? (Specify Yo pan, Mexican, Puerto Rican,	etc.)	Black, White,	
036	al', o	Ď	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: BL	ACK
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show its Modical Expiration rout be modified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usual Occu (Give kind of work done	during most of working	16b. K	Kind of Business/In	dustry
121	within she.	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSE KEE	-0-0	A	MIANC	E
	filed Hygie othar ant,	e Co	12 TH GRADE 17. Father's Name (First, Middle, Last)	1100001100	18. Mother's Name (First	, Middle, Maider	Sumame)	
Maryland	d fall	To Be	JOSEPH	VINES	5	ALBERTA	7	DAV!	S
ary	2 should and Men is marks aumetic	-	19a. Informant's Name/Relationship	**	19b. Mailing Address (Street				
	s 1 and 2 if Health itam 27 i		JERRIE MOR				MORE, I	ND 212	202
ore	Pages 1 nent of He int: If itan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	Place of Disposition (Name of cemetery, crematory or other place	Date		ocation - City or To	
Baltimore,	Pa and Pa		`4 ☐ Donation 5 ☐ Other (Speci	(Y) KING	a memorial P	ARK 03-10-26	05 BAC	TIMORE,	MAKSUHNU
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	N. Willian	NO JOSEPH P Q140 N. FL	ess of Facility J. BROWN 3 OLTON AVE, B	R. FUN ALTIMOI	RE, MD	21217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	h. Do not enter the mode of dy	ing, such as cardiac or respi	ratory arrest,		Approximate Interval Between
Ш	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Hyp	Oxic Respir	atory Fa	ilure		2 hours
	/Medical Examiner		resulting in ocality			J			11 1
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	uence of):				11 days
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C					
o,	ate be executed sysician and he burial-transit	Exa	resulting in death) Last	Due to (or as a consequence	uence of):			1	
8760,	that the death certificate be exed by the attending physician detached for use as the buria	lcal		d					
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as It	Completed by Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancy				
Вох	attend for us	clan	23b. Was decedent pregnant in the past 12 months?	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 □Ectopic pregnant	су		23d. Date of delive Month	ery Day Year
P.O.	the d ry the ached	ysi	1 □ Yes 2 No 9 □ Unknown	9□ Unknown	out. Out of (bpoorty)				
	s that ned b e deta	y PI	Part II. Other significant conditions				3e. Did tobacco	use contribute to th	ne cause of death?
Records,	w requires been sign should be	ed t	Acquired Ir	nmunodeficien	cy Syndron	16	1 ☐ Yes 2	No 3□ Prob	ably 4 Unknown
ecc	law re as be 2 sh	plet				24	la. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
- B		Con				1[performed? Yes 2 No	death?	200No
Vital	Physician: The law this certificate has be ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	0	26. Place of Death (Chec			
of	Phys r this ral dir	- T	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 DOA 28b. Time of 28c. Inju	ther: 4 Nursing Home 5	☐ Residence escribe how inju		y)
O	Attanding F r death. ector: After by the funera	tlon	1 Natural 5 Pending investigation	(Month, Day Year)	Injury Wo	ork?]Yes 2 □No		,,	
Division	I or Attandi after death. Director: A I in by the fu	Iffica	3 ☐ Suicide 6 ☐ Could not to determined		ome, farm, street, factory, office	28f. Lo	cation (Street ar ty or Town, State	nd Number or Rura	il Route Number,
Ö	tel or s afte al Dir ed in	Cert	4 - Homicide	busiding, etc. (<i>Specin</i>)	y)		ly or Town, State	")	
	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death occurred at the tition and/or investigation, in my	ime, date and place, and du opinion, death occurred at the	e to the cause(s ne time, date and) and manner as st d place, and due to	tated. the cause(s)
	To the vithin 3	Me	29b. Signature and title of certifier	1		se number		ite signed (Manth,	Day, Year)
			> Scart K	_ M.D.	Rt	ES-000	Ma	irch 5	, 2005
C	11	-1	30. Name and address of person who	completed cause of death (Item Tohns Hoskin	n 23a) (Type, Print) Towa s Hospital Goo N	er 110 Docto	r's Lo	unse	1
	Sta		31. Date filed (Month, Bay Year) MAR 0	32. Regiaràr's Signa					
	Regist	ar	and V	(LOU)	K ASS				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** webster-Bey HOWARD 4:45 PM 03 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland madical System Baltimore City If Under 1 Year | If Under 24 Hrs. | 6 Sax 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 213-52-2972 Days Yrs. Director EPTEMBER 27,1944 MARI Usual Residence of Decedent 10b County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show the Medical Examinar must be notified at NA 1 Yes 2 □ No BALTIMORE Funeral Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2215 DREMI AVENUE items 23e filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed by "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED UPHOLSTER or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Pages 1 and 2 should be WEBSTER HOWARD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other treu once. BROWN OREM AVE, BALTIMORE, MD. 21217 (MOTHER) 2215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State GEL AIR MEMORIAL CARDON 03-11-2005 BEL AIR, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
50SEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTIMORE, MD 21217 which N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Yhars /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed tran and Due to (or as a consequence of): burial sician Box 68760. Physician/Medical the phy IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. pe 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Tes 2₺No 1 TYes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D Hospital 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 7105 P18599 MD If reason who completed cause of death (Item 23a) (Type, Print) LHarington M.D. 225. Greene St. Baltimore, MD 21201

State Registrar

Registrar's Signature

Amarda

Physician /Medical Examiner **Funeral** Director al Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumetic event 2008. **Physician** /Medical Examiner

death. Director

Whitehorst, James

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) ^{Day} 2005 James Robert Whitehurst March 8, 7:15 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

Months Days Hours Min.

Min. June 3, 1933 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 1**∑**M 2□F 173-26-2675 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford 1 ☐ Yes 2X No Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 922 James Street 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rhea Marie Gardiner Rev. Guion Gladstone Whitehurst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 511 Forest Valley Drive, Forest Hill, MD 21050 James P. Whitehurst/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 3-10-05 * 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOGE disease or condition resulting in death) 3 weeks Due to (or as a consequence of): CEREBROUBCUCINC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine) I ANSETES that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death Month Day 5 Cher (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARD 10 MY OPATHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗌 Yes 2VZ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 3€ No 1 Enpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D022843 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R - PH/LUIN 1-005 WWC FBD PHILLIPI 2005 RUCK SPRING M 31. Date filed (Month of Year) 32. Pagistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Funeral

within 24 To the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 83 AM **Physician** MARC /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** TIMORE II Under 24 Hrs. Min. THE JOHNS HOPKING HOBPITAL N/A 7. Age (In yrs. last birthday) 76 yrs. If Under 1 Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🔀 F Director APRIL 27, 1928 N. CAROLINA 219 30 9331 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 shov other traumatic avent, it a Medical Exactrof must be notified at MD N/A BALTIMORE 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1407 N. POTOMAC STREET 21213 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ∑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3X Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) llth COSMOTOLOGY OWNER BEAUTY SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Menta item 27 is marked GEORGE HARDING REBECCA Pages 1 and 2 should nent of Health and Men 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DERICK WILLIAMS (GRANDSON) 1407 N. POTOMAC STREET BALTIMORE, MARYLAND 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of Himportant: If ite any njury or ot 1 Burial 2 □ Cremation 3 □ Removal from State DRUID RIDGE CEMETERY MARCH 12, 2005 BALTO, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** monara 12 hours resulting in death) /Medical Due to (or as a consequence of) Examiner ty Deep-Venous Thrombosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Day 4 Pregnant at time of death 5 Other (specify) P.0. the th 9 Unknown 9 Unknowf signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 3 ☐ Probably 4 ☐Unknown 1 TYes peeu 24b. Were autopsy lindings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 No certificate 2 No 1 🗌 Yes or Attending Physician: director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Jetely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 🗀 Suicide Place of Injury · At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceuther 30. Imme and address of person who completed cause of death (Item 23a) (Tipe, Print) -111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

		1 - For State Registrar	State of M	laryland		artment <i>tificate</i>			ınd Mer		jiene leg. No.	005	07	954
		1. Decedent's Name (First, Middle, La	est)						2.	Date of Dea Month	th Day	Year	3. Time	
Physi /Med			Evelyn	Virg	inia	Walte:	r			3	4	2005	3:4	5 AM
Exam		4a. Facility Name (If not institution, gi	re street and number))		4b. City, To	own, or Lo	cation of	f Death			unty of Dear		
		FRANKLIN SQUA	ZE HOSPITA	L CEN	ITER	R	05 FD	ALE	-		1	BALTIN	10RE	
Funera	1	Social Security Number 6.	Sex 7. Ag	ge (In yrs. la		If Under 1 Months		Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birt	hplace (State	or Foreign
Directo	r	213-07-0010	1 □ M 2 🛣 F	87	Yrs.					uly 1			ryland	
В ,		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	cation						-	10d. Inside (Pity Limite
aryla shov	_			Toc. City	, rowiror Lo	Cation			Dur	dalk				s 2 TNo
8a-f	scto	Maryland Balt	rmore	1		1			Du1.		0	- (118		-27
vith ti	Director	10e. Street and Number				10f. Zip C	ode				log. Citizer	of What Co	ountry?	
ath v	<u>ra</u>	136 Patapsco A			140				21222	Was as No.		ited S	States	
er de Item	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	5. 13.	f Yes, specif	y Cuban, N	Mexican,	, Puerto Rica	/ Yes or No- an, etc.)	14.	Black, Whit		
36 rs aft		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			1 ☐ Yes 2	X No S	Specify:			Sp	ecify:	White	
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-1 show alcal Exercited at	be	15. Decedent's E			16a. Dece	dent's Usual	Occupation	n			16b. Kind	of Business	Industry	
15 n 72 n n	piet	(Specify only highest gi		F.1)	(Give	kind of work DO NOT use	done durir retired)	ing most	of working				•	
2121 1 within jiene. r then "	Completed by	12 Years	College (1-4or	5+)	Hon	nemake	r				Ow	n Home	3	
Ind 21215-0036 be filed within 72 hours after death with the Marylan tal Hygiene, then "natural", or liems 23a or 28a-1 show event, if a Medical Exercite rinest be notified at	BeC	17. Father's Name (First, Middle, Las	1)	·			18	B. Mother	r's Name (F	irst, Middle,	Maiden Su	тате)		
	ToB	George Perry G	reen						Lot	tie R	bert	a Rich	nards	
Shou should will be mail	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street and	Number	r or Rural R	oute Numbe	r, City or To	own, State, 2	Zip Code)	
re, Maryla s 1 and 2 should f Health and Mer itsm 27 Is marke other traumatic		Eileen M. Knigh	t / Daught	er	136	Patapa	sco A	Ave.	Dunc	lalk,	Maryl	and 2	21222	
		20a. Method of Disposition	75	1 00	ace of Dispo	sition (Name	of er place)		Date		20c. Locat	tion - City or	Town, State	
Page Nent o Int: If		12€28urial 2 ☐ Cremation 3 12€28urial 2 ☐ Cremation 3 ☐ Other (Spec		9	k Lawr	-		3/7	7/2005	5	Balt	imore	, Maryl	and
₽ 2225	ij	21. Signature of Funeral Service Lice	insee /		22	Name and	Address o	of Facility	v					
W FOE	MILE	Attplance	Masser	1	70	ida-ku 122 Wi	ck fu	inera 70-	ar Hon Dunda	ne of 1	ounda arvla	nd 2	1C. 1222	
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that cause	the death	. Do not ent	er the mode	of dying, s	such as o	cardiac or re	spiratory arr	est,		Approxima Interval Be	ate etween
Pnysicia		Immediate Cause (Final	METAS		CAS	TRIC CH	ARCIN	HOM	A				Onset and	Death
/Medica		disease or condition resulting in death)	Due to (or as			11400								
Examine	r	Conventially list conditions	b											
- 7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Little Unidentifying Cause (Disease or injury	Due to (or as	s a consequ	ience of):								5	
cuted	Examine	that initiated events	c											
760, <sbr></sbr> s be executed sicien and burial-transit		resulting in death) Last	Due to (or as	s a consequ	ience of):									
8760, sate be exphysicien the buria	lical		d			-								
as a s	Medi	IF FEMALE:												
Box sath cert attendin for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 🗌 Fetal	death 3	Ectopic pres					23d	 Date of del Month 	ivery Day	Year
o.O. In the degraph the arrange tached for	sici	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of de	eath 5	Other (spec	cify)						,	
P.O nat the d by the letache	Phy	Part II. Other significent conditions	contributing to death	but not racu	Iting in the u	ndoshina on	uco awan is	in Port I		23a Did to	hacco use	contribute to	the cause of	death?
IS, P res that signed to be deta	b		FIBRILLATI		inting in the d	nderlying cat	230 GIVOIT II	iii aiti.		1 🗆 Y	لده		obably 4	
cord w require been si	eted	- City) MINING	10/Clookin	0.1										
Vital Records, sician: The law requires t certificate has been signer rector, page 2 should be a	Completed									24a. Was a autop:	SV	prior to	utopsy findings comptetion of	s available cause of
	S									perfor	2 X No	death? 1 ☐ Yes	2 □ No	
/ita clan: ertific ector,	Be	25. Was case referred to medical examiner?	Hamitali (4)				1	6. Place	of Death (C	heck only or	16)			
of Vita Physician: this certific	은	1 Yes 2 No	Hospital: 1 X Inpati		ER/Outpatier		- 1			5 Resid			cify)	
	lon:	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time o Injury	M 280	c. Injury at Work?	: s 2□N		. Describe h	ow injury o	ccurred		
Attending rr death.	icat	2 Accident investigation	be One Blace of le	siune - At bo	ma farm et			3 4 🗆 1		Location (S	treet and N	lumher or Pi	ural Route Nui	mher
in Diriginal	Certification:	4 Homicide determine	building, e	tc. (Specify))	eet, factory,	onice		201.	City or Tow		rumber or At	Ital Floure Ivul	noer,
To the Hospitel or within 24 hours after To the Funerel Dis completely filled in		29a. Certifier 1 🛣 Certifying F	hysicien: To the bes	t of my know	wiedne desti	n occurred at	t the time	date and	d place and	due to the o	alico(c) an	d mapper as	stated	
Hos 24 hc Fun stely	edical		miner: On the basis	of examinat										(s)
To the Hospitel within 24 hours of To the Funerel completely filled	Med	29b. Signature and title of certifier	-			29c.	License nu	umber		2	9d. Date s	igned (Mont	h, Day, Year)	
F 3 F 3		b/an. Vh	eun		M	0	DS	564	77		3 -	4-2	2005	
		30. Name and address of person who	completed cause	death (Item	3a) (Type,	Print)			. /			, ,		
7		Dr. GLENN MEIN					LUARE	= DR	IVE.	BALTIN	TORE	MD	21237	7
	State	31. Date filed (Month, Day, Year)	32. egisi	trar's Signat								1		
Regi	•	MAR 0 9	2005	w d										

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland	•	artment of H tificate of L			jiene Jeg. No. 2	005	07956
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, La Robert 4a. Facility Name (If not institution, gi JOHNS HOPKIN	VI MOYE	dical	4b. City, Town, or	. 1	2. Date of Dea Month O3 ath	Day O 6 4c. Coun	Yeer 2005 Ity of Death N/A	3. Time of Death $g: 2bc_{\text{IM}}$
	Funeral Director			Sex 7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year)	9. Birthp Coun MARY	lace (State or Foreign try) LAND
	72 hours after death with the Maryland natural', or Iteme 23e or 28e-f show dical Expodrat mast be notified at	Funeral Director	10a. State 10b. County MD • N/A 10e. Street and Number 4916 GUNTHER AN 11. Marital Status	/E .	LTIMO	RE 10f. Zip Code 21206		(Specify Yes or No-		f What Coun	an Indian,
d 21215-0036	filed within Hygiene ther than int, I've Me	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) -3- 17. Father's Name (First, Middle, Las.	College (1-4or 5+) - 0	6a. Deceo (Give life. L	Yes, specify Cuba Yes 2 No No North Nor	Specify: ation furing most of w		Special Specia	PARTS	CK
, Maryland	1 and 2 should be in Health and Mental. Health and Mental. tem 27 is marked out her treumatic ever	To Be	19a. Informant's Name/Relationship	OMMOWN		•	LILLI	AN WILMOR	E r, City or Tow	n, State, Zip	
Baltimore,	permit. Pages 1 s Depertment of He Importent: If Item any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ 1 ☑ Donation 5 ☑ Other (Special Service Lice	Removal from State DRUII	etery, cren DRID IBNE#R		ERY 3-10 s of Facility P	D-2005 I	JNERAL	ORE, M	ARYLAND
	Pnysician /Medical Examiner		Immediate Cause (Final disease or undition resulting in leath)	Due to (or as a consequent)	Do not enter	ardio w	g, such as card	ac or respiratory arr		, IMKI	Approximate Interval Between Onset and Death WARM GUM
8760,	ate be executed hysicien and he buriat-transit	cal Examiner	S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Acute Due to (or as a consequen	iver	- fail	ure				days 6 years
O. Box 68	iaw requires that the deeth certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
Records, P.	w requires that the bear signed by should be detact	b	Part II. Other significant conditions	contributing to death but not resultin	ng in the ur	nderlying cause give	n in Part I.	. 1□Y	es 2 No	3 Proba	
Vital Rec	The ete ha	Be Completed	25. Was case referred to medical examiner?					24a. Was a autops perform 1 Yes	med? 2.2 No	prior to con death?	nsy findings available inpletion of cause of
Division of \	or Attending Phy Iter death. Director: Atter this in by the tuneral d	Certification; To	27. Manger of Death Natural 2 Accident 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day Year)	b. Time of Injury		at	Home 5 Residence 28d. Describe he 28f. Location (Sincity or Town	ow injury occu	urred	
	To the Hospitel or Attent within 24 hours etter death To the Funerel Director: completely filled in by the	Medical C	(Check only 2 Medical Exa	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	dge, death and/or inv	restigation, in my op	ninion, death oc	curred at the time, d	ate and place	, and due to	the cause(s)
	on Twit	7	29b. Signature and title of certifier Dr. Bag 30. Name and address of person who	M. D.	Ba) (Type	29c. License Re			9d. Date sign Marc		, 2005 MOYE MD
4	Sta Regist		31. Date filed (Month, Par Year)	2005 32. Refistrar's Signature	ns E	SMC 4	940 F	castem A	ve.	Baiti	more MDA
DH	MH 17 Rev 1/2	001			-						

			Please	State of Marylar				-	_	ole.
			1 - State Registrar		Cei	rtificate of l	Death	Re	g. No.	07957
	Physici	an	1. Decedent's Name (First, Middle, Las		2			2. Date of Deat Month	Day	3. Time of Death
	/Medic			YOUNGBAR		45 City Taylor	dentine of South	3		Year 10.22 PM
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County	
	Euroval		180 Southwood 5. Social Security Number 6. Se		last birthday)	Pasade	If Under 24 Hrs.	8. Date of Birth		Arundel 9. Birthplace (State or Foreign Country)
	Funeral Director			□M 2 □ F 68	Yrs.	Months Days	Hours Min.	(Month, Day, 05/31,	/1936	Country) SC
	pu >		Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Lo	nation				10d. Inside City Limits
	shov	5	MD Anne A:		asader					1 ☐ Yes 2 ▼No
	ath with the Marylan 123a or 28a-f show nast be notified at	Director	10e. Street and Number	runder Fa	asauei	10f. Zip Code		10	0g. Citizen of V	Vhat Country?
	3a or		180 Southwood	b.c.q		21122)		U.S.	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race	e - American Indian, k, White, etc.
9	after dea or Items	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 No	Specify:	7 1110411, 010.7	Specify	•
8	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show disal Evaninat rust be mailled at	d by	3 Widowed 4 □ Divorced	Year or Dates:	16a Daga	dent's Usual Occup	ation			White
15	in 72	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	kind of work done of DO NOT use retired	ation during most of work f)	king	160. Kind of Bu	isiness/Industry
212	filed within Hygiene. other then "	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Hor	nemaker			Own H	lome
Maryland 21215-0036	e file al Hyg I othe vent,	Bec	17. Father's Name (First, Middle, Last)	,			18. Mother's Nam	ie (First, Middle, A	Maiden Surnam	е)
ylaı	should be tond Mental I s marked o umetic eve	Tof	Daniel Simmer					Luchia		
Mar	2 shot and Is mu		19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Number.	City or Town,	State, Zip Code)21122
	s 1 and 2 should be filed within 72 hours after des if Health and Mental Hyglene. Item 27 is marked other then "naturel", or Items other treumetic event, Tra Medical Examinar in		Bruce Youngbar 20a. Method of Disposition	20b, F	Place of Dispo	sition (Name of				sadena, MD City or Town, State
no			1 ■ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crei	matory or other plac	· 1			arnie, MD
Baltimore,	고두주름		21. Signature of Funeral Service Licen							ral Home, PA
ä	permii Depar Impor any Ir		12/1/20		1.7					, MD 21122
	Ø.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	ENJOME	TRIAL	- CAR	CINOM.	A CIT	RUS	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
4		ē	Sequentially list conditions,	b. Due to (or as a consec	uence of):					
Г	uted 3 ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	,	. ,					
oʻ.	e be executed rsician and burial-transit	Exa	resulting in death) Last	Due to (or as a consec	(uence of):					
3760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai		d						
89 ×	leath certificate I attending physi I for use as the b	Physician/Medic	IF FEMALE:	00. //						
Box	ath coattend	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Feta	uldéath 3.[Ectopic pregnancy			23d. Date Mor	e of delivery nth Day Year
o.	that the de ned by the a detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of c 9□ Unknown	igatii 5L	Other (specify)		-		
٦	that ned by deta	by Ph	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ribute to the cause of death?
rds	w requires to been signed should be		Diabeties.					1 □ Ye	s 2 No	3 ☐ Probably 4 ☐ Unknown
000	law requasis peen	piet	HYPERTE	NSCOTY				24a. Was ar		Vere autopsy findings available prior to completion of cause of
Vital Records,		Completed	,	PIDEMIA	3			perform	ned?	leath?
/ita	sicien: Th certificate rector. pag	Be (25. Was case referred to medical examiner?			Out		th (Check only one	э)	
of	Physi this o	Ţ	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatier 28b. Time o		4 LI Nursing H	ome 5 - Feside 28d. Describe ho		
	ding I h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Worl	Yes 2 □ No	200. Describe no	w injury occurr	50
Division	ten leat tor: the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h				28f. Location (Str	reet and Numbe	er or Rural Route Number,
Ö	el or safter	Certification:	4 Homicide	building, etc. (Special	fy)			City or Town	, State)	
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	ledical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and ma ate and place, a	nner as stated. and due to the cause(s)
	o the vithin o the	Me	29b. Signature and title of certifier	and mainter states.		29c. Licenso	e number	29	_	i (Month, Day, Year)
	F > F 0		1 Kank	100 m		1	7737		3/4	105
	1		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,			11.0	, /	EN BURNIE
	Q		KAM K. KA	STOBI MY	75	75 1	1 TCHIE	- 1th)	1,42	EN BURNIE
	Sta -Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					
Dr	Regist		MAR	0 9 2805	in A	A section	9			
טר	vii i / Nev 1/2	100		E. F.		6				

ORIGINAL

		i	FUI	artment of Health and Mertificate of Death	
	Dhyoisi	on.	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
	Physici /Medic		Matilda Louise Zimmerman		March 4, 2005 9:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 9000 Briarcroft Lane #308	4b. City, Town, or Location of Death Laurel	4c. County of Death Prince George
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		
	Funeral Director		579-48-8252 1 M 2X F 91 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington, DC
	pu ≱ sali		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Maryla f sho	Į.	MD Prince George Laurel		X□Yes 2□No
	r 28e-	rect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with	alD	9000 Briarcroft Lane #308	20708	USA
396	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other then "natural", or items 23a or 28e-f show injury or other treumetic event, If a Modical Examinet must be notified at a jury or other treumetic event, If a Modical Examinet must be notified at a.g	by Funeral Director	11. Marital Status 1	Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	hin 72 ho s. sn "natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of workin DO NOT use retired)	16b. Kind of Business/Industry
21	ad with	Com	12 0 Cle	rical	National Geographics
Maryland	should be filed with and Mental Hygiene is marked other the sumetic event, the	Be	17. Father's Name (First, Middle, Last) Charles Frederick Zimmerman		(First, Middle, Maiden Sumame) . Kohler
7	should be nd Mental marked c	2			Route Number, City or Town, State, Zip Code)
	1 and 2 s Health ar tem 27 ls			Montcalm Place, St	
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 Burial 2 (Xcremation 3 Removal from State Cemetery, or 4 Donation 5 Other (Specify)	osition (Name of Distriction of Paratory or other place) 1. Chematory 3/12/	20c. Location - City or Town, State Lawrel, Maryland
alti	permit. Page Department of Importent: If any injury or once.				eck Funeral Home, Inc.
	207 2 2 2				oad, Laurel, Maryland 20707
1	Physician /Medical Examiner		28a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or beart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) Due to (or as a consequence of):	2	respiratory arrest, Approximate Interval Between Onset and Death
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or at a consequence of):	nsion	10 years
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unden vin Cause (Disease or injury that initiated events c.	_ doubetes	10 years
8760,	tate be executed by sician and the burial-transit	cai	resulting in death) Last Due to (or = a onsequence of): d		
P.O. Box 68	The law requires that the death certificats are been signed by the attending phy page 2 should be detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	s that ned by a deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rds	v requires been slgi should be	ed b			1 Yes 2 No 3 Probably 4 Unknown
eco	e law requ has been je 2 shoult	plet			24a. Was an autopsy findings available prior to completion of cause of
E	The cate h	Completed			performed? death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No
Vital Records,	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death Other: 4 All Nursing Hor	7.02
of	Phys r this eral dir	To	27 Manner of Death 28a. Date of Injury 28b. Time	all 30 DOA 40 Indising Hon	ne 5 ¥ Residence 6 □ Other (Specify) 8d. escribe how injury occurred
ion	nding F th, r: After e funera	atior	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	al or Attendi s after death, if Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
•	To the To the Comp	W	29b. Signature and title of certifier Paul M	29c. License number 1 43237	29d. Date signed (Month, Day, Year) March 7, 2005
	10,		30. Name and address of person who completed cause of death (Item 23a) (Type Paul Armstrong (4201 Laure)	f/C, Da. #102 L	aurel, mo. 20707
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9		
DH	IMH 17 Rev 1/2		HIMIN U & ZUUS	Speciel	
		201	ORIGIN	AL	

Unknown 05–01574 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - 1	For State Registrar	State of Maryland / Dep Ce	ertificate of Death	vieritai mygier Reg.i	4000	07959
0.		cedent's Name (First, Middle, L	ast)		2. Date of Death	Day Year	3. Time of Death
Physician /Medical		RALPH	I HMADI		March 02	2005	7:17 A ^M
Examiner		acility Name (If not institution, g		4b. City, Town, or Location of Death		4c. County of Death	74.0
		100 Queensberry	Sex 7. Age (In yrs. last birthda	White Marsh White Marsh White Marsh White Marsh	8. Date of Birth	Baltimo 9. Birthpla	re ace (State or Foreign
Funeral Director		4020 P60	TO M 2 F HO Yrs.	Months Days Hours Min.	(Month, Day, Ye	ar) Couinti	RIA
₹ -count		I Residence of Decedent State 10b. County	10c. City, Town or	Location		10	d. Inside City Limits
r 28e-f show Inotified at irector	Ch.	March Ball	THEI SOME	- 22 - 1			1 ☐ Yes 2 ∰ No
be notified	10e.	Street and Number	MACHE MACH	10f. Zip Code	10g.	Citizen of What Count	ry?
0 A	1	OD QUEENSB	CAD ROAD	2/237		NIGERIA	
or Items 23.		Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
or in	1	Never Married 2 Married Widowed 4 Divorced	1 ☐ Yes 2∰ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: G	a V
		15. Decedent's	Education 16a. Dec	pedent's Usual Occupation	16b	. Kind of Business/Indi	ustry
	Ele	(Specify only highest gementary/Secondary (0-12)	rade completed) (Gill life College (1-4or 5+)	ve kind of work done during most of wor . DO NOT use retired)	king	_	Λ\ ··
other then and the Man		19182	717 SULT	00-05/270m32	US (C)	OCAL FOOL	1 ARKET
B & G	17. F	Father's Name (First, Middle, Las		18. Mother's Nan	ne (First, Middle, Maid		3.0
Item 27 Is marke other treumetic To	19a.	Informant's Name/Relationship	(Type, Print) 19b. Ma	iling Address (Street and Number or Ru	ral Route Number, Cit	ZGINAM by or Town, State, Zip of	-
	74	JapA. Acoli	KA-AMADI 100	JULICELEN ROPO	DITHAI	DASH MAG	MAN
Item 27		Method of Disposition	20b. Place of Dis		Pate 20 20c	Location - City or Tow	vn, State
ent: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation — 5 🖒 Other (Spec	Hamovai trom State PORT — H	ARSOURT 200	25 , LOG.	Watsh-13	T. OLKA
Department of near Importent: If Item 2 any Injury or other 2006.	21.	signature of Funeral Service Lin	ensee	22. Name and Address of Facility	(JEWOG: 2	2 00 2	48816
2 E e 0	20-	CREE TIME	Alianiana that assumed the death. De not a	8800 HARFORD RE	40 HARKY	1775/ 1064,	Approximate
	4	shock, or heart failure. List on lediate Cause (Final	milications that caused the death. Do not end one cause on each line.	inter the mode of dying, such as cardiac			Interval Between Onset and Death
ysician Nedical	dise	ase or condition ilting in death)	a. GUNSHOT WOULD Due to (or as a consequence of):	UD TO HEAD	AND M	ELL	
aminer			200 10 (01 23 2 0011304001100 01).				
ner ner	Seq	uentially list conditions, y leading to immediate se. Enter Underlying se (Disease or injury	Due to [or as a cons⊋quence of]:				
ial-transit	tnat	se (Disease or injury initiated events Ilting in death) Last	C				
		and the second	Due to (or as a consequence of):				
as the bur			d				
attending for use as		EMALE: Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliver	y
for for		in the past 12 months? 1 ☐ Yes 2 ☐ No		B⊟Ectopic pregnancy □ Other (specify)		Month I	Day Year
se a		9 ☐ Unknown	3LI OTKIOWII			I .	
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signed by the at the detached for by Physical	Part		s contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	
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			1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygiei	ZUUD U/95U
			Decedent's Name (First, Middle, L.	ast)		2. Date of Death	3. Time of Death
	Physici /Medi		CHARLE	G B ADA	MS	MARCH	Day Year 6-00P M
3	Examir		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Dea	h	4c. County of Death
			Genesis - K	orightwood	Luther VIII-	e	BAltimore
	Funeral		20, 11,00	Sek [7. Age (In yrs. last bir 1Д M 2□F	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	70	113.	2-8-23	MARYLAND
	aryland show		10a. State 10b. County	10c. City, Town	n or Location		10d. Inside City Limits
	Many 1-f sh	호	MD Baltir	noce L	thecuille		1 Tyes 2 No
	th the	Director	10e. Street and Number	0.1101	10f. Zip Code	10g.	Citizen of What Country?
	deeth with the Maryland ms 23a or 28a-f show rmust be notified at	ai	515 Bright	rield Na.	21093		USA
		Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s effe	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 1 No Specify:		Specify: h Lo
21215-0036	within 72 hours efter ene. than "natural", or ite he Medical Examina	edt	15. Decedent's 8		Decedent's Usual Occupation	16h	Kind of Business/Industry
15	n "na n "na Medik	Completed	(Specify only highest gi Elementary/Secondary (0-12)	ade completed)	(Give kind of work done during most of wo life. DO NOT use retired)	rking	Time of businessamassiny
212	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesman	6	rienspring Dairy
þ	be filed within 7: ital Hygiene. id other than "n. event, Ine Madi	Вес	17. Father's Name (First, Middle, Las	9		me (First, Middle, Maid	en Sumame)
<u>/a</u>	should be filed withing and Mental Hygiene.	ျာ	Charles Ac	dans	Bener	dicta t	Sean
Maryland	s 1 and 2 should f Health and Men tem 27 ie marke other traumatic		19a. Informant's Name/Relationship		Mailing Address (Street and Number or R	ural Route Number, Cit	y or Town, State, Zip Code)
	of Health litem 27		Jenniter 111.	Deffendall 10	90 Little Creek	Kd., Orla	ndo FL 32825
ore.	m 0 = -		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 [cometer	Disposition (Name of y, crematory or other place)	Date 20c.	Location - City or Town, State
altimore,	tmen tant:		' 4 □ Donation ' 5 □ Other (Special	LACTION	cineal Chapet-beltir	5-9. OS F	orest HII, MD
Bal	permit. Page Depertment Important: If any injury o		21. Signature of Funeral Service Lice	disee 20	22. Name and Address of Eacility V		movium MD 21093.
			23a Parti Enter the disease or con	notigations that caused the death. Do	PCACE FOL ALTEROY		ERAL - CLEMPTONCH Approximate
			shock, or heart failure. List only Immediate Cause (Final		not enter the mode of dying, such as cardia		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. MULTIP Due to (or as a consequence of	LE SCLEROS	15	4862
	Examiner			C O P D	л).		years
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×	be executed icien and burial-transl	EX	resulting in death) Last	Due to (or as a consequence of	of):		
8760,	cate be execut physicien and the burial-trar	dical		d			
9		(D)	IF FEMALE:	00-14			
Вох	eath certifi attending for use as	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
P.0.	at the de by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		,
٦.	£ 29 €	F.	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
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la		e C	25. Was case referred to medical		OS Blace of De	1 ☐ Yes 2 ☐ Ath (Check only one)	1 ☐ Yes 2 ☐ No
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ō			27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Injury at	28d. Describe how in	
jo	ttending F death. ctor: After y the funera	atio	1.☑f¶atural 5 ☐ Pending 2 ☐ Accident investigation		njury Work? M 1 ☐ Yes 2 ☐ No		
<u>Vis</u>	ol or Attending after death. I Director: After d in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not to determined		m, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
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	Hospitel 14 hours a Funerel I	edicai	(Check only 2 Medical Exa	hysician: To the best of my knowledge miner: On the basis of examination and	death occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		
	7. ½ ₹ §	-	Signature and the Of Certifier	10 Le Min	250. Literise number	29d. L	Date signed (Month, Day, Year)
	10	-	20 None and 11	マーマーフ	120053150	N	ARCH 747 2005
	Y		Su. Name and address of person who	completed cause of death (Item 23a) (MB POBOX630	73 8171	COT (176 MD
	Sta	te_	31. Date filed (Month, Day, Year)	32. Signature	1 4	-,	ARCH 7 7005
	Danie A		MADIA	2005 👫	Conste 8		

State of Maryland / Department of Health and Mental Hygiene 5 1 - For State Registrar Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death **Physician** racch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Luthervill Ave Evans If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 69 Yrs. 5. Social Security Number Funeral 9. Birthplace 32-6112 1**/2** M 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28e-1 ehow other treumatic event, the Medical Examinar must be notified at Baltimore Lutherville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? $u \cdot J$ Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", any injury or other treumatic event, the Medical Exagnes. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1#4or 5+) lech. 17. Father's Name (First, Middle, Last) Be nacle Glenn cyife, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Marie (nee Merendino, 2 Evans Ave. Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
'4 ☐ Donation 3 ☐ Other (Specify) March 9,2005 vans Funeral Chapel 22. Name and Address of Fagility matives Funeral + Cre 21. Signature of Funeral Service Licensee Enter the disease, or complication or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death liver disease Immediate Cause (Final disease or condition resulting in death) hosis **Physician** years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the a à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death. To the Funerel Director; After this certificate has b autopsy performed Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) State Registrar

Reva A. Ayres 05-01612 RJ

	1- For Amend Item 1&Unpend Item	m 23a, pt	rtificate of Death 3			07962
Physician	Decedent's Name (First, Middle, Last)			2. Date of Dea	Day Year	3. Time of Death
/Medical	Reva Ann Ayres		45 O'S. T	March		08:59 PM
Examiner	4a. Facility Name (If not institution, give street and number) 67 White Birch Drive		4b. City, Town, or Location of C North East	Death	4c. County of Death Cecil Co	unty
Funeral Director	5. Social Security Number 6. Sex 7. Age 1 M 2 F 7. Age	(In yrs. last birthday) 39 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, May 24.	, Year) Coui	
pu ≥	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				
death with the Maryland ms 23a or 28a1 show rmust be rolified at		North East				0d. Inside City Limits 1 ☐ Yes 2 No
or 28a	10e. Street and Number	NOITH East	10f. Zip Code	1	0g. Citizen of What Cour	ntry?
ath w	67 White Birch Drive		21901	U:	nited State	S
urs atter	3 ☐ Widowed 4 ☐ Divorced		Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F 1 ☐ Yes 2 🛣 No Specify:	? (Specify Yes or No- luerto Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
ed within 72 hours at ygiene. Per than "natural", or it, the Medical Exem Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/In	dustry
filed within Hygiene. Ther than and, the Mer	10		site Technician		Aerospace	
be file d oth avant	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, M	Maiden Surname)	
and 2 should be filed within 7 and 2 should be filed within 7 a 27 is marked other than "rer traumatic avant, its Med To Be Comple	Richard Shorter, Sr.			a Mae Hamm		
12 st h and 7 is n traun	19a. Informant's Name/Relationship (Type, Print)	le s	ng Address (Street and Number of			
iges 1 and it of Health it is it is m 27 or other t	Larry Ayres/Husband 20a. Method of Disposition	20b. Place of Dispo	Lte Birch Drive		t, Mary Land 2 20c. Location - City or To	
ages ant of tt: if it	1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	cemetery, crer Hockessin	natory or other place) Crematory Ma:		ockessin, De	
permit. Pages 1 ar Department of Hea Important: If Itam any injury or other	21. Signatur Tuneral Servicine ee	Compa	Name and Address of English	2005		
permit. Departr imports any inju	Visle Ve		27 South Main S	Crouch Fund		land 21001
Physician	23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line immediate Cause (Final	he death. Do not ent e.	er the mode of dying, such as car	diac or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical		consequence of):	rdiovascular di	sease		
Examiner	Construction flat and distance	,				
n e e	Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Cause (Disease or injury	consequence of):				
executed on and rial-transit	that initiated events c.					
icate be executed physicien and s the burial-transit	Due to (b) as a	consequence of):				
E 4 E	d.					
The law requires that the death certifies has been signed by the attending sage 2 should be detached tor use as completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown IF FEMALE: 23c. If yes, outcome of 1 □ Live birth 2 1 □ Yes 2 □ No 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
res that igned b be deta by Pt	Part II. Other significent conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?
w require been sig should b	Chronic obstructive pulmona	ary diseas	e, fatty liver	1 Ye	s 2 No 3 Prob	ably 4 ☑ Unknown
The law requir				24a. Was ar	24b. Were auto	csy findings available
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certificate rector, pag	25. Was case referred to medical			Death Check onl one	9	
ding Phys After this tuneral dia	1 X Yes 2 □ No Hospital: 1 □ Inpatien 27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day	t 2 ER/Outpatien 28b. Time of Injury	t 3 DOA Other: 4 Nursin 28c. Injury at Work? M 1 Yes 2 No		nce 6 (X Other (<i>Specif</i> y w injury occurred	At scene
To the Hospital or Attanding P within 24 hours atter death. To the Funaral Director: Aiter t completely tilled in by the tuners Medical Certification:	3 □ Suicido 6 □ Could not be	y - At home, farm, stre (Specify)		28f. Location (Str City or Town	reet and Number or Rura , State)	l Route Number,
o the Hospital Ithin 24 hours a the Funaral I mpletely tilled	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of 2 ☑ Medical Examiner: On the basis of earth manner state	xamination and/or inv	occurred at the time, date and p restigation, in my opinion, death of	lace, and due to the ca occurred at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier		29c. License number OCME	29	9d. Date signed (Month,	
	Joshan Treenker	9 MAD	OCME		March 4, 2	UU5
	30. Name and address of person who completed cause of de Taska Z Greenberg, M		Print) 111 Penn Str	eet Balti	more, Marvl	and 21201
State	31. Date filed (Month, Day, Year) MAR 1 0 2005	's Signature	60		,,	
Registrar	MAR 1 0 2005	's Signature				

State of Maryland / Department of Health and Mental Hygiene

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1	/Medic Examin		4a Facility Name (If not insti	itution, giv	e street and number	r)				4b. City, Town, or I	ocation of Deat	4c. County	of Death		
- Ł			Millennium	Fran	klin Squa	re				Baltin	ore		NA		
	Funeral Director		5. Social Security Number 218–48–3707 Usual Residence of Decede		I M 2 TE	ge (In yrs. I 61	last birth Yı	Month	er 1 Yea Days		8. Date of Bir (Month, Da 7-18-	th ly, <i>Year)</i> 43	9. Birthp Cour	place (State ntry) Md .	e or Foreign
	fand Mand	Ì	10a. State 10b. Co			10c. City	, Town	or Location					1	10d. Inside	City Limits
	or deeth with the Marylar terms 23a or 28a-1 show ner must be notified at	ģ	Md.	NA		В	alti	more						1 X Y	es 2□No
	h the	Funeral Director	10e. Street and Number			I.		10f. 2	ip Code			10g. Citizen of	What Cour	ntry?	
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	Herne :	ne	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U,	S.	13. Was Dec	edent of ecify Cul	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No			can Indian,	
21215-0020	urs aft	፩	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive		1 ☐ Yes 2 X If Yes, Give Year or Dates	No.				Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specif		ack	
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121		直	Elementary/Secondary (0-		College (1-4o	5+)				ed)	v				
2	A Select		12th grade 17. Father's Name (First, Min	della diamet			n	omemak	er	18. Mother's Nam	o /Eirot Middlo	Own Ho			
auc	a de la la la la la la la la la la la la la	å	Leroy	JOIE, LEST,		7									
Z	hould d Me d Me marka	ို	19a. Informant's Name/Rela	tionshin (Tuna Print)	Ave	-	Mailing Addre	es (Strae	Cather			alker		
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ē,	Hear Hear other	1	20a. Method of Disposition	011	Daugiit	20b. P	lace of E	Disposition (N crematory or	ame of	Street,	Date	20c. Location	City or To	Dwn, State	
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aiti	orter	1	21. Signature of Funeral Ser							ess of Facility	-	imore, M		21202	
ä	Department of the sany is		Jeren.	1.6	hapu					H. East		E. North	ı Ave		
			23a. Part1. Enter the diseas shock, or heart failure.	e, or com List only	plications that cause one cause on each	ed the death line.	. Do no	t enter the m	de of dy	ing, such as cardiac	or respiratory a	rrest,	i	Approxim Interval B Onset an	iata Between
	Physician /Medical		Immediate Cause (Final		1	11/1	0		,0	O HOS			1	Olisot all	TA A C
	Examiner		disease or condition resulting in death)		a	IVE	K		(K	RHUS	12			YE	ARU
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ó	deeth certificate be assouted e attending physician and of for use as the burtal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J		200 10 (0.			,.				1		
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	nd pr		rooming in occur, can	L									1		
Box	ath ce ttendi	Physician/			d										
		န	Part II. Other significant cor	ditions o	ontributing to death	but not resu	ilting in t	he underlying	cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the caus	e of death?
P.0	requires that tha deeth cer sen signed by the attendir hould be detached for use	£	HEPA	M	ITIS						10	Yes 2□ No	3 ☐ Proi	bably 4	Onknown
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Ö	v require been si should	6									perfo	med?	ava	ailable prio	or to
Rec	hes t	Completed									Cardo	. N/.		death?	56
ā	Physician: The lev this certificete hes rei director, page 2		25. Was case referred to me	dical						OC Plans of Pass	th (Chapterstee		1	Yes 2	IQNo .
Vitai	Physician: r this certific rei director,	6	examiner?	ioicai	Hospital:	ient 2 🗆	ER/Outp	atient 3 [OA O	26. Place of Dea	The second second	dence 6 □Oth	er (Snecif	έν)	
ð	r this	⊢ į.	27. Manner of Death		28a. Date of In (Month, D		28b. Tir	ne of	28c. Inju			how injury occur		"	
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Division	Attai ar dee by th	<u>₹</u>		ould not be etermined	28e. Place of II	njury - At ho		n, street, facto	ry, office		28f. Location (a	Street and Numb	er or Rura	il Route Ni	umber,
ō	is after or led in led in	Certification:	×		Jones St.	,-py									
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	To the Within 2 To the comple	¥	29b. Signature and title of ce	rtifier /			Α	2	c. Licen	se number		29d. Date signe	d (Month,	Day, Year,)
			▶ Mattoa	off	_	M.	1).		DOL)5849	5+1	MARC	H	42	1005
	,)	.	30. Name and address of pe	rson who	completed cause of	death (Item	23a) (T	ype, Print)						-	
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28f. Location (Street and Number or Rural Route Number, City or Town, State) 332 Highland Dr #1			
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cause(s)			
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cause(s)			
I.			

DHMH 17 Rev 1/2001

_			State of Maryland	/ Depa	rtment of H	ealth and Death		Reg. No		07965
	Physicia		1. Decedent's Name (First, Middle, Last) Ralph Harold Bourquin, Sr.				2. Date of D Month	Da Da	y 2005	3. Time of Death 12:44 pm
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Agnes Health car	2	4b. City, Town, or Balt	Location of De			c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la. 020-14-3792 1型M 2口F 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	lin. 8. Date of Bi	7191	9. Birt 9 Mass	hplace (State or Foreign untry) achusetts
	ryland how			Town or Lo	cation					10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, it a Medical Erain or timet be rotified at ONCB.	ecto	Maryland Baltimore 10e. Street and Number		10f. Zip Code	Baltim	ore	10a C	itizen of What Co	1 Yes 2 No
		ai Dir	1218 Black Friars Rd.		2122	28			ted Stat	
36		by Funeral Director	11. Marital Status 1 □ Never Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☒ Yes 2 □ No 1945 If Yes, Give Year or Dates: 1961		Vas Decedent of Hi f Yes, specify Cubai I ☐ Yes 2 [™] No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or N lierto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
2-00	72 hour natural lical E	ted b	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation	working	16b. H	Kind of Business/	Industry
Maryland 21215-0036	uld be filed within 7 fental Hygiene. rked other than "n tic event, the Med	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	working	U.:					
		ro Be (17. Father's Name (First, Middle, Last) Paul Albert Bourquin				Name <i>(First, Middle</i> Slavin	e, Maidei	n Sumame)	
Mary	12 shoi h and h 7 Is ma rrauma		19a. Informant's Name/Relationship (Type, Print) Ralph Bourquin, Jr. (Son)		g Address <i>(Street a</i> Southfiel			-		
ře,	s 1 and f Healti item 27 other 1	l g	20a. Method of Disposition 20b. Pla	ce of Dispo	sition (Name of natory or other place		Date Date		ocation - City or	
Baltimore,	Page Iment o tant: If jury or		'4 □Donation 5 □Other (Specify) Garr	icon	Forest	n3/	11/2005	Owi	ngs Mill	s, Maryland
Balt	permit. Departi		21. Signature of Funeral Service Licensee MUQUulloch MO1425	2 i6	The and Address 30 Edmond	ss of Facility W Ison Av	e., Cator	nera. nsvi	l Home o	f Catonsvill 21228
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.			g, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence)		a					a weeks
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		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
8760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a conseque	ence of):						
687	ate hy:	Medic	IF FEMALE:							
λίζ/γ 0. Βοχ	Physician: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	teath 3□	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
$\mathbb{Z}_{\mathcal{C}}$ rds, P.		5	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause give	en in Part I.			/	the cause of death?
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Vital		Be	25. Was case referred to medical examiner?		t 30 DOA Othe	N. P.	Death (Check only			
200		n: To	27. Manner of Death 28a. Date of Injury 2	R/Outpatien 28b. Time of Injury	1 3 DOX	4 🗀 (40) 3111	g Home 5 Res 28d. Describe			cify)
Sion	tent death tor: the	icatio	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆 \	Yes 2 □ No	28f Location	(Street a	nd Number or Pi	ıral Route Number,
Solvi	or afte Dir	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Social Not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, iann, sin	eet, factory, office		City or To			rai noute ivaniber,
X	To the Hospital or within 24 hours after To the Funeral Director completely filled in I	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.							
	within To t	Σ	29b. Signature and title of certifier		29c. License		7	29d. Da	ate signed (Monti	h, Day, Year)
	12		30. Name and address of person who completed cause of death (Item 2)	23a) (Type,	Print)	100	Baltin	DD	100/	21229
:	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 0 2005 MAR 2 0 2005	ire Soci	Lesto,	n ave	JULITAL	NYTE	2) [1] []	31491
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dica		1. Decedent's Name (First, Middle, s Sandra S. Burl	*				2. Date of Dea Month March 5	Day Ye	3. Time of Death	
nine	_	4a. Fecility Name (If not institution, g	give street and number	er)	4b. City, Town, o	r Location of Deat		4c. County of I	Death	
		602 Idlewild 1				Air		Harford		
al or		5. Social Security Number 387-30-2537 Usual Residence of Decedent		70 Yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 10,	1934 V	Birthplace (State or Foreign Country) VISCONSIN	
	ğ	10a. State 10b. County	rd	10c. City, Town or L	ocation Be1 Ai	r			10d. Inside City Limits	
	Funeral Director	Md. Hallo. 10e. Street and Number 602 Idlewild	Road		10f. Zip Code	.014	0g. Citizen of Wha	t Country?		
	۾	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2[If Yes, Give Year or Date	s? No	r in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4c	16a. Dec (Giv. life. 15	edent's Usual Occup e kind of work done DO NOT use retired brarian	eation during most of wor d)	16b. Kind of Business/Industry			
á	To Be C	17. Father's Name (First, Middle, La Joseph M. Sym	•	'		18. Mother's Nar Willa	Maiden Sumame)	niden Sumame)		
1		19a. Informant's Name/Relationship Harold H. Bur	(<i>Type, Print</i>) ke/husband	19b. Maii 602	ing Address (Street 2 Idlewild	and Number or Ru l Road, B	ral Route Number Sel Air,	Md. 21014	țe, Zip Code) ŧ	
		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		20b. Place of Disp cemetery, cre Mt. Zion	osition (Name of ematory or other place U.M. Ch.	Cem. 3/1		20c.Location-City Bel Air,		
ouce		21. Signature of Funeral Service Lic	1111		22. Name and Addre	Funeral				
n al		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Lu	sed the death. Do not en line.				brain	21014 Approximate Interval Between Onset and Death	
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3	icai Exa	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	as a consequence of): ne of pregnancy 2 Fetal death 3	□Ectopic pregnancy			23d. Date of Month	*	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 055 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March BehRENS **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DALTI MORE Kaluda boutimore If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MARY LAND 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 M 2 KF -24-444e(Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 28e-f show nust be notified at 1 ☐ Yes 2 No BALTIMORE BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21236 Items 23g Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. other traumatic avant, the Madical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No ō Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced "netural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none and Mental Hygie is marked othar 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baumaastner the indeman. 2 19a. Informant's N. a/Relationship (Type, int) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saluda pd. Barring et MD 21236 permit. Pages 1 and 2. Department of Health ar Important: If itam 27 is any injury or othar trau once. Dehrens Denbic 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Caerison For the Concerning 3-10-05 Concresson M. 22. Name and Address of Fabrity BACTI MORE MD 21234. GARRISON MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee EVANS FUNERALCHAPEL, 8800 HARFORD RD. no U 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final / disease or condition resulting in death) Physician 1 wet meumania /Medical Due to (or as a consequence of) primary disease Examiner yours Chs hochoe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner for use as the burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12/months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown CONGESTIVE 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/1/No 1 ☐ Yes 2 ☐ No 1 Yes

tha Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, hours after death unaral Diractor: thin 24 hours after tha Funaral Dira mpletely filled in b Be Completed 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 4 🗋 Nursing Home Certification: To 28c. Injury at Work? 27. Manner of Death 1 Watural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D31295 1239 Name and address of person who completed cause of death (Item 23a) (Type, Print)

5,10

State Registrar DHMH 17 Rev 1/2001 KLOSSZ

MAR 1 0 2005

31. Date filed (Month, Day, Year)

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32. Pegistrar's Signature

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			For	State of Ma	State of Maryland / Department of Health and M					Mental Hygiene 2005 07000				
			1 - State Registrar	Certificate of Death				F	0/900					
			1. Decedent's Name (First, Middle, L	ast)		1		2. Date of Dea	ath Day	Year	3. Time of Death			
3.	Physici -/Medic		1205841	N i	Bie	/		MARCH		2005	4:00 A M			
	Examin		4a. Facility Name (If not institution of	ve street and number)			Town, or Location of De	ath		nty of Death				
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⊕ F	uneral		Social Security Number 6.		e (In yrs. last bii	thday) If Under		rs. 8. Date of Birt	h Vonel	9. Birthp	lace (State or Foreign			
	irector		212-05-1663	1□M 200 F	97	Yrs. Months	Days Hours M	in. 8. Date of Birt	1918	m 12 P	YLAND			
			Usuel Residence of Decedent		0									
ylan	how		10a. State 10b. County	. 1	10c. City, Tow	n or Location	_			1	Od. Inside City Limits			
× a	Fig.	tor	IND Ba	Itimore	2	parn					1 ☐ Yes 2 ☐ No			
h the	128	ire	10e. Street and Number		Or) (10f. Zip	Code		10g. Citizen o	of What Coun	ntry?			
death with the Maryland	23a c	Funeral Director	14208 Nove	Creekin	ay 20	28	21152			USF	7			
deat	E E	Jer	11. Maritat Status	12. Was Decedent		13. Was Deced	ent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No-	14. R	ace - Americ				
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US af	- i	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dales:		1 ☐ Yes 2	No Specify:		Spe	city: Wh	VITC			
within 72 hours after	ical	Completed	15. Decedent's t	Education	16a	Decedent's Usua	l Occupation k done during most of v	vorking	16b. Kind of	Business/Inc	dustry			
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Z A WIT	른콥	TO.	12			Home	emaker		000	NHO	ome			
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VIGING Z 12	marked other than "natural", or liems 23s or 28s-1 show matic event, the Medical Examinar must be notified at	To E	charles n	newsn	au		mar	rgaret	50	hae	eter			
should sold Man	rinnt: If item 27 is marked other than "natural", or items 23a or 28a-1 shov njury or othar traumatic event, the Medical Examinar must be redified at		19a. Informant's Name/Relationship	(Type, Print)	1/ 196	. Mailing Address	(Street and Number or	Rural Route Numbe	r, City or Tox	vn, State, Zip	Code)			
and 2	27 is r trau		C. Andrea B	rennaN	midte	14208	DOVE Cre	CK Was	Six	irks,m	02/15/			
	ten otha	1	20a. Method of Disposition		20b. Place o	f Disposition (Nam	ne of	Date	20c. Locatio	n - City or To	wn, Stete			
Pages	y or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		EVAN	f Disposition (Nam ry, crematory or of VS FUNEY	al 3	8/05	Fores	+14:1	1 000			
Dartmo	Important: If item any injury or otha	-	21. Signature of Funeral Service Lice		cho	ue I - Bel	Address of Facility	or of all	trnanu	1111	1,1110			
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-	2-63		222 Part 1 Enter the disease of	rolicar os val cause	OVICE Do	not enter the mode	of thing such as card	lian or respiratory as	11003	' 11	Approximate			
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	sician		Immediate Cause (Finat disease or condition resulting in death)	_aCo	NGEST.	or it	H-T TSH	2016			LUEZKS			
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OU, B be executed	urial		resulting in death, cast	Due to (or as	a consequence	of):								
ate b	been signed by the attending physician and should be detached for use as the burial-transit	licai		d										
OrdS, P.O. BOX 687	ng p	ompleted by Physician/Medi	tF FEMALE:					1						
DOX	tendir r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnancy 2 Fetal death	3 □Ectopic pre	egnancy	JIA		Date of delive	*			
dea	ne at ed fc	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at 9☐ Unknown	time of death	5 Other (spe	ecity)	17.		Month	Day Year			
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COLUS, w requires t	is ue	ed	IRON - DEFF	-1213219	MEN	LIA		1 1 Y	'es 2□No	3 Prob	ably 4 ⊡Unknown			
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The law	age age	E						- autop perfor	med2	death?	impletion of cause of			
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e ig	Afte	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Da	y Year)	njury M	Work? 1 ☐ Yes 2 ☐ No							
UIVISION or Attanding	ctor y the	Certification:	3 ☐ Suicide 6 ☐ Could not	be Ope Place of Ini	urv · Al home, fa	irm, street, factory	office	28f. Location (S	treet and Nu	mber or Rura	l Route Number,			
	Dira	erti	4 Homicide determine	building, et	c. (Specify)			City or Tow	n, State)					
spita	fillec		29a. Certifier 1. Certifying P	Physician: To the best	of my knowledge	a, death occurred :	at the time, date and pla	ace, and due to the o	ause(s) and	manner as et	ated			
Hos	To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exs	aminer: On the basis o	f examination ar	id/or investigation,	in my opinion, death or	courred at the time, of	date and place	e, and due to	the cause(s)			
o tha	o the	Med	29b. Signature and title of certifier	1)		29c	License number		29d. Date sign	ned (Month, L	Day, Year)			
F- 3	: ⊢ ర		John I	(Tivon	_ we)	D00207		-					
	1			V	- a /e ==									
	2		30. Name and address of person who	completed cause of c	eath (Item 23a)	(Type, Print)	O OSLER	00 73	e Sani	M	2,204			
	- 01		31. Date filed (Month, Day, Year)	•	ar's Signature	- 3			- 41		(
	Sta Registr		MAD 10		K	Secretar								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Brown ichae 0246 Fe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner 10KE 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) tf Under 1 Year Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 **X**M 2 ☐ F 212 50 634 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar partment of Health and Mental Hygiene.
ortant: If Item 27 is marked other than "naturel", or Itema 23s or 28s-f show injury or other traumatic event, Ite Madical Examine must be notillised as Ma Baltimore 1 Pres 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code NOak 2120 48 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iruck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be BeHy ဂ 591 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mippie River MA Leverte permit. Pages 1 and 2.
Department of Health at Important: If Item 27 is any injury or other trau 1408 K 20b. Place of Disposition (Name of or ether place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility nonva 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cances tmmediate Cause (Final disease or condition resulting in death) Lung Physician Venn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to miniociae cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a pursuouence of Hospital or Attending Phyaician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XYes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 2□ No 1 🗌 Yes 1 Yas funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 Tes 2 No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weinberg Conce, Frs7 NO Di Fronklir 32 Registrar's Signature State Registrar

			State of Maryland / Department of Health and More and Maryland / Department of Health and More and Mor		20115	07970
	Dhuaisi		1. Decedent's Name (First, Middle, Last)	2. Date of Death	ay Year	3. Time of Death
	Physici /Medic		Elluid SENSER	FEB, di	42005	6 + 45 M
+	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore	4	County of Death	one
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth (Month, Day, Yea		place (State or Foreign
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	nyland thow	L	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	he Ma	ecto	mD Baltimore Baltimore 100. Street and Number 101. Zip Code	10- 6	110 6 140 1 O	1 ☐ Yes 2 ☐ No
	3a or	Funeral Director	109. Street and Number 109. Zip Code 21224	109. 0	citizen of What Cou	nuy?
	r death	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto Forces)	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	can Indian,
36	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Iteal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: W	nite
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Maryland	should be nd Mental nmarkad umatic av	To E	Frederick Benser Margo	aret	Shum	
Mar	id 2 sho lth and 27 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural MK. Cliffold Densey 310 H. Mountain		or Town, State, Zi	ry MD
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic avent. The Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio		Location - City or T	own, State
Baltimore,	nit. Pages vartment of l ortant: if its injury or o			13-05 Ba	Himore	MD 21224
Bal	permit. Pag Department Important: any injury c once.	1	21. Signature on Fugeral Service Licensee 1. Signature on Fugeral Service Licensee 22. Name and Address of Facility 3. KARDA & UNI	ERAL F	TOME	212224
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Approximate Interval Between Onset and Death
	Pnysician /Medical	9	disease or condition resulting in death) Due to (or as a consequence of):	5 - M	1	
	Examiner		Sequentially list conditions, b. And Ribnthui			
V	ned Insit	Examiner	Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events Carpart The Date of C			
oʻ	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):			
8760	death certificate be executed e attending physician and nd for use as the burial-transit	ledical	d			
Box 6	eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of deliv	өгу
0.8	at the deat by the atte tached for	hysician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		Month	Day Year
σ.	th,	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to I	he cause of death?
ords	w requires been sign should be		<u> </u>	1 Tes	2 vo 3 □ Pro	pably 4 Unknown
Vital Records,	S S S	ompleted	6 AMTT	24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
tal		e Co	25. Was case referred to medical 26. Place of Death	performed? 1 Yes 2 X	o 1 ☐ Yes	2 No
of Vi	Phyaician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence	6 ☐Other (Speci	(y)
	ding h. After funer	tion:	1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how inj	ury occurred	
Division	or Attending after death. Diractor: After in by the fune	ertification;	2 Accident	8f. Location (Street a City or Town, Sta		al Route Number,
ā	urs afte	0				
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(d at the time, date a	s) and manner as s nd place, and due t	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	_	ate signed (Month,	Day, Year)
•			024276	1 2	. 220)	
	lo		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2801 Hudson St. Dr. Simon Scaling			
	Sta		31. Date filed (Merin Pay, Tea) 2005			
	Registi	ar	MANUAL AT ASSAULT			

Edward J. Brun 05-1713 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Unpend Item 2 Registrar	State of Maryland / D 23a-b, 27, 28a-f per	epartment of Health me G842 4-14-0 Certificate of Death	and Mental Hy Tas	ygiene Reg. No.
Physicia /Medic		Decedent's Name (First, Middle, Lass Edward Joseph	•		2. Date of D Month March	eath 2005 Year 10:45 A M
Examin		4a. Facility Name (If not institution, give 213 Sandee Road 5. Social Security Number 6. Si	street and number)		24 Hrs. 8. Date of B	4c. County of Death Baltimore inth 9. Birthplace (State or Foreign
Director		Usual Residence of Decedent	X 48	rs. Months Days Hours	Min. (Month, D	21 1956 MD
winin /z nouis atter beath with the Maryland ane hen "naturel", or leams 23a or 28a-f show he Mszdical Exameret must be twotthed at	Director	MD Baltimo	ore T	or Location imonium		10d. Inside City Limits 1 ☐ Yes 2 ▼No
23a or 28	al Dire	10e. Street and Number 213 Sandee Rd.		10f. Zip Code 21093		10g. Citizen of What Country? USA
rei', or items Exercise re	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1 ☐ Yes 2√2 No Specify	n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
giene. sr then "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired) ndscaper	st of working	16b. Kind of Business/Industry Landscaping
dental Hygrked othe	To Be C	17. Father's Name (First, Middle, Last) Francis B. Brun	, Sr.		er's Name (First, Middle rie M. Pier	
th and N 27 ie ma trauma		19a. Informant's Name/Relationship (7	^{Турв, Print)} 19b. , Jr./brother 21			ber, City or Town, State, Zip Code)
Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "naturel", or Items 23a or 28a-f shov any injury or other traumatic event, Ita Medical Expriner must be multiled at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Company 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen Michael J. Fla	Removal from State Balto.	22 Name and Address of Facili	itv	Laurel, MD Dulaney Valley, Inc. nium, MD 21093
physician and Medical Street S	edical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Asphyxia Due to (or as a consequence of the con	head f):		Interval Batween Onset and Death
ittending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
in signed by the a uld be detached f	þ	Part II. Dther significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part		tobacco use contribute to the cause of death? Yes 2 \(\subsection \) No 3 \(\subsection \) Probably 4 \(\frac{\frac{1}{2}}{2} \subsection \) No nown
certificate has been si rector, page 2 should	Completed				1 20 es	prior to completion of cause of death? 2 No 1 Aves 2 No
n. After this funeral di	atlon; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	found		28d. Describe	one) sidence & Other (Specify) at scene how injury occurred unk
- 0 D	Certification;	3 Suicide 4 Homicide 6 X Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office unk	28f. Location City or To	(Street and Number or Rural Route Number. un own, State)
within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and/or investigation, in my opinion, dea	nd place, and due to the ath occurred at the time	a cause(s) and manner as stated. , date and place, and due to the cause(s)
To the comp	M	29b. Signature and title of certifier	1. Xid mo	29c. License number OCME		29d. Date signed (Month, Day, Year) March 9, 2005
		30. Name a d address of person who d	completed cause of eath (Item 23a) (Type, Print) 111 Penn S	treet Balt	imore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene U 5

1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 4th 6: 18 PM March Melvin T. Baldwin, Sr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** AGNES HEALTHCARE BALTIMORE SAINI N/A6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 28, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Maryland 75 212-26-6248 Director Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rthan "natural", or Items 23a or 28a-f shov The Modical Expediente ust be nutified at **Funeral Director** Baltimore 1X Yes 2 No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U. S. A. 404 South Longwood St. or Items 12. Was Decedent Ever in U.S. Amned Forces? 1 ∑Yes 2 □ No 1951-14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Mailman Post Office Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbur Baldwin Margaret Butts ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Crouse, daughter 1305 Inverness Ave. Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or Bayview Crematory 03-09-05 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, 21. Signature of Funeral Service Licensee Inc. chou. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician 6 DATS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, I any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gunsequence of: Physician/Medical Examiner burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Wasan 2 No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16705 MB 1 mil 1 MARCH, 4th, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTHONY MD. 900 SOUTH CATON AVENUE, BALTIMORE, MB 21229 DAFFOE - BONNIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	laryland		artmen rtificate				lental Hy	gien Reg. N	Fra U	05	07973
	Physic		1. Decedent's Name (First, Middle, Las	it)				-			2. Date of De Month		ay	Year	3. Time of Death
	/Medi		Margaret Helen B									7 20	005		5:00A M
7	Exami	ner	4a. Facility Name (If not institution, give	street and number)				Location of	of Death		4		of Death	
_			1133 Hollins St. 5. Social Security Number 6. S	0 7 A	ge (In yrs. lasi	t hirthan (1)	Ba1 If Under	timo	re If Under	24 Hrs	P. Data of Riv	45	n/a	-	alace (Caste - Familia
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	yland		10a. State 10b. County		10c. City, T	own or Lo	cation							1	Od. Inside City Limits
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	or 28	Olre	10e. Street and Number				10f. Zip	Code				10g. C	itizen of	What Cour	ntry? ·
	ath w	rai	1133 Hollins St				1	1223					USA		
	er de Items	Funerai	11. Marital Status	12. Was Deceden Armed Forces	?	13.	Was Deced f Yes, spec	lent of Hi ify Cuba	spanic Ori n, Mexican	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-		ce - Americ ck, White,	
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	of Health item 27		Phillip T. Brusio	-son	last St	621	Shiple	ey B	d. I		icum.				
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Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Len	500 Mars -	. 0	22	. Name and	d Addres	s of Facilit	y Lou	idon Pa	rk i	uner	al Ho	ome
	40240		TAPL DU	warig							altimo:		MD 2	1229	
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Э. В	the att	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant a			Other (spe						Мо	nth	Day Year
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	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowle	dge, death	occurred a	at the time	e, date and	d place, a	and due to the	cause(s	s) and ma	nner as st	ated.
	n 24 i	edicai	(Check only 2 Medical Examone)	iner: On the basis of and manner s	of examination tated.	and/or inv	estigation,	in my op	inion, deat	th occurre	ed at the time,	date an	d place, a	and due to	the cause(s)
	To the Hospital or At within 24 hours after d To the Funerel Direct completely filled in by	ž	29b. Signature and title of certifier	- 11			29c.	License	number			29d. Da	ate signed	(Month, L	Day, Year)
			weyas) atter	1 ding	Plu	secu	an	1	162	00	MA	RCH	+ 7,	2003
	٠,٨		30. Name and address of person whe			a) (Type,	Print)		as f	-	1	_		. 11	2005
	10		N.M. MACHIRA		720	1-0	MAIL	EN	Chi	occe	26A,	CA	TON!	sville	21228
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	die	de								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Feb 7:41.0 Simon Bobich /3 2005 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner University of Md Hospital Baltimore Hours Min. 8. Date of Birth (Month, Day, Yes Aug 28, 19 Birthplace (State or Foreign Country)
 unk If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** Days 1⊠M 2□ F Months 71 054-48-3238 Director Usuel Residence of Decedent filed within 72 hours efter death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner count be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Pasadena Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zio Code 21122 7808 Mayford Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 N Married unk 1 ☐ Yes 2 ☒ No Specify: 21215-0020 Specify. white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk 15. Decedent's Education (Specify only highest grade completed) i. Peges 1 and 2 should be filed within timent of Health and Mental Hygiene. Tant: If fem 27 is marked other than " ijury or other traumatic event, the Me College (1-4or 5+) Elementery/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Neme (First, Middle, Last) unk unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) University of Md Hospital 22 S. Greene Street Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Signature of European Service Licensee Kona)Ld S. Wade 22, Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician tmmediate Cause (Final disease or condition resulting in death) /Medical 15 minues Condiac compthomas Examiner Due to (or es a consequence of): Physician/Medical Examiner 6 monhs Carelomyenethy Dilaled • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours effecteeth.
• Funeral Director: After this certificate has been signed by the attending physician and nding physiclan and use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available pricr to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Dey Year) 28c. tnjury at Work? 28d. Describe how injury occurred 27. Mennet of Deeth 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 030494 2118105 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) University specifity respited Gal south oderles st Balhmare AND OK DES A/mo V1230 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State MAR 1 0 2005 Registrar

SIMON

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 MARCH 8, **Physician BOREN** J. 6:55 A M STUART /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK FREDERICK NORTH HAMPTON MANOR Hours Min. B. Date of Birth MAR. 27, 1941 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 □ F 63 NY 094-32-5066 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 77 is marked other than "netural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 ¥Yes 2 □ No FREDERICK Director FREDERICK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 USA 200 E. 16TH STREET Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 00 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify. WHITE 3 ☐ Widowed 4 🏋 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-**PROPRIETOR** SHOE STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **BOREN** KIRSCHTEIN CEIL HERMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6308 IVERSON TERRACE - FREDERICK, MD 21701 Health Item 27 ROBIN HERMAN / DAUGHTER other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State ò Department of Importent: If any injury or once. WELLWOOD CEMETERY 03/09/2005 PINELAWN, NY ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Tola 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shy Dager Syndrame **Physician** disease or condition resulting in death) 18031 '/Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transil that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No certificate 2 No 1 Yes After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 □ No Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after on Funerel Direct filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mary fet burell mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK MD 21702 0 65 c JOHN SON 32 Registrar's Signature 31. Date filed (Month, Day, Ye State Registrar

			1- State of Maryland / Department of Healt Certificate of Dea	th and Mental	Hygier	2005	07976
_	_		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date	Reg. I	No.	10 Time (10 m)
	Physicia	an	DONALO E COY	Month	1	Day Year	3. Time of Death
	/Medic		O	MAG		7 200.	
	Examin	er	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Locati Howard Conn, 7 Gin Hospital Cocun			4c. County of Deat	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un		-4 Diah		
	Funeral Director		1 M 2 □ F Months Days Hou	urs Min. (Mont	of Birth h, Day, Yea		hplace (State or Foreign untry)
			121-18-4728 7.7 Tis. Usual Residence of Decedent	Nov	18,	1927 Ne	w York
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	r 28e-f show	ţ	MD Howard Columbia				1 ☐ Yes 2 No
	n the	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	untry?
	deeth with the Maryland me 23a or 28e-f show Findel Le rediffed at		5544 Bluecoat Lane 21045	5	1	United S	States
	72 hours after death with "naturel", or iteme 23a or allout Eventual hand bear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specify Yes		14. Race - Ame	rican Indian,
٥	or it		1 Never Married 2 Married 1 Yes 2 No)	Black, White	
ğ	hours after turei', or ite	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: Wh	ite
15-0036	"nati	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during to	most of working	16b.	. Kind of Business/	ndustry
7	within 72 ane. than "nai	gE.	Elementary/Secondary (0-12) College (1-4or 5+)				_
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Ë	should be and Menta marked umatic ev	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu				
<u>8</u>	7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Beverly B. Coy/ Wife 5544 Bluecoat				
a)	s 1 and f Heelth item 27 other to	1 8	20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place)	Date Date		La PID 2	
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altımore,			'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fac			Laurel,	MD
n B	permit. Departrimportrimports		$\sim m \sim c \sim 1$	Witzke	Fune	eral Hon	nes, Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	MICTIS KO	-	olumbia,	MD 21045 Approximate
			shock, or heart failure. List only one cause on each line.		,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) aa.				
	Examiner		Due to (or as a consequence of): RESPIRATORY FA	HLURE			
		ē	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	120			
	uted	Examine	Cause. Little Underlying Cause Disease or injury The injury of the Community of the injury of the i	PULMINA	7 0	SE MJE	
<u>,</u>	be executed ician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
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9	as 유트	a)					
Box	n cert andin use	<u>\</u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
	The law requires that the death certifit te has been signed by the attending p age 2 should be detached for use as	Physician/M	in the past 12 months? 1			Month	Day Year
O.	t the by th tache	hys	9 Unknown				
	res that signed b	ру Р	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	Part I. 23e.	Did tobacc	co use contribute to	the cause of death?
Vital Records,	w require been signature		CARDIOM TOPATHT		1 🗌 Yes	2 No 3 Pr	obably 4 ZUnknown
ပ္ က	e law re has be je 2 sho	pie			Was an autopsy	24b. Were au	topsy findings available
ř	eicien: The l certificate ha rector, page 3	Completed			performed es 2/2/1	? death?	completion of cause of 22No
<u> </u>	ien: rtifica	Bec	25. Was case referred to medical examiner? 26. P	Place of Death Check		110	
<u>-</u>	nyeic nis ce I dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	☐ Nursing Home 5 ☐	Residence	6 ☐Other (Spec	rify)
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Division of	endi eath. or: A the fu	cati	2 ☐ Accident investigation M 1 ☐ Yes 2	2 🗆 No			
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion,	te and place, and due to death occurred at the t	the cause ime, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	thin 2 the mple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License numb			Date signed (Month	
)	L M L S		290. Signature and title of certified ATTEN 672 5 DO0 16 9			MCH &	
	/						
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAMES TANSIND A 522 DOLPHIN STREET B	BALTIMORE	1	0 2121	+
	-01						
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
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		•	1- For State of Maryland / Separtificate of Death Certificate of Death	Reg. No.
1	Physicia	an .	1. Decedent's Name (First, Middle, Last) Betty J. Cole 2. Date of De Month	Day Year
	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	6 2005 915 PM
	Examin	er	Sinai Haspital Battinore	4c. County of Death
1/2/0	Funeral Director		5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. 8. Date of Bir (Month, Days) 1 Months Days Hours Min. Nov 27	y, Year) Country)
O	and w	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Colonia	the Marylar 28a-f show	Director	MD N/A Baltimore	XXYes 2 □ No
N	or death with the Maryla tems 23a or 28a-f shor et must be rodiffed at		10e. Street and Number 1306 West 40th Street 21211	10g. Citizen of What Country? U.S.A.
Bathy	, 즉 근육	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Specify: White
€ \$ 3×		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th College (1-4or 5+) Sales	Department Store
3 bc	be filed stal Hygi of other	Be C	17. Father's Name (First, Middle, Last) Lawrence Douglas 18. Mother's Name (First, Middle	
S S S S	should b and Menta marked umatic e	70	Hazel Agnes l	
V-vo w√ Marvland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numb Kathryn Damico (Daughter) 1306 West 40th Street Bal	ACCES WILLO DESCRIPTIONS
	s 1 and f Health item 27 other ti		20a. Method of Disposition 20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
thent	Pages ment of ant: If it		LakeView Memorial 3/9/05	Sykesville, MD
Cth.	permit Depart Import any in		21. Signature of Funeral Service ticensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral 3031 Falls Road Balto, Mi	Н <u>ете</u> 11 ^{Inc} .
	<u></u>		23a. Part Elter the disease, or competations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, of heart failure. List only one cause on each line.	
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	isease 10 years
	Examiner			
, ,	ed sit	liner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury	
V	rificate be executed og physician and as the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):	
68760	ate be hysicia the bur		d	
	sertifica ding pl	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
D Box	es that the death cer igned by the attendir be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	Month Day Year
	uid be deta	þ	Tall III all I	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Yunknown
Olivicion of Witel Bocordo	The law requirements the has been simple 2 should be a	Completed	24a. Was auto porti	
	ian: ian: artifica ctor, p	Be C	25. Was case reterred to medical examiner? / Liberton / Check only	one)
>	ding Physician: The h. After this certificate hi funeral director, page	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Res	dence 6 Other (Specify) how injury occurred
2	ding I th.: After a funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? M 1 Yes 2 No	now injury coconica
1	or Attence fler death pirector: n by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, wn, State)
	To the Hospital or Attending Physician: The law requires that the death cewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	ledical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the desired examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	cause(s) and manner as stated. date and place, and due to the cause(s)
	o the vithin 2 the comple	Med	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	->-0		Elel Rolly mD (LES-000)	3/6/05
	1.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edeural Radden MD Sino Haptal of	3 11
	φ		31. Date filed (Month, Day, Year) 32. Registrary signature.	valtin one
	St. Regist	ate rar	MAR 1 0 2008 - Marie M. 1 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	

Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a per Dr., G841, 03/10/05dbb 9, per FH Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Month Physician AM 1050 Rose Palazzolo Colletti /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMONE ST. AGNES HEALTHCARE **Baltimore City** 9. Birthplace (State or Foreign Country)

Ttaly If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 F Days Hours Yrs. 84 Director 101-26-0152 November 2, 1920 Italy Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location or Itams 23a or 28a-f show other trust be notified at 1 Yes 2 No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 5616 Freshaire Lane U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1□Yes 2XNo ō Baltimore, Maryland 21215-0036 Specify. Specify 3 Widowed 4 □ Divorced þ White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Medical Laboratory Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event. Itel 12 Phlebotomist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Salvatore Palazzolo Vincenza Esatti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5129 Wellinghall Way Columbia, Maryland 21044 Mr. Fred Chiccone Son in Jaw 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 03/02/2005 Ascension Cemetry 22. Name and Address of Facility Monsey, New York 21. Signature of Funeral Service Linensee MOIS93 Slack Funeral Home, P.A. 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death PS Immediate Cause (Final disease or condition resulting in death) CEREBRAL VASCULAR ACCIDEN Physician /Medical Due to (or as a consequence of): BOLISM Stage IV **Examiner** Cancer Gastric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 attending physician by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2/1 No 2 No 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Injury Division 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation death 2 Accident in by the **Director:** 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours after To the Funeral Dire

State

PALAZZOLO

31. Date filed (Month, Day, Year) MAR 1 0 2005

CA

IDN

29b. Signature and title of certified

30. Name and address of pere

00

29a. Certifier

Medical

on who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature, BOAL

Registrar

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Mar		epartment of I Certificate of			ene () ()	15	07980	0
	Physici	an	1. Decedent's Name (First, Middle,	Last)	(212	rad		2. Date of Death Month	Day	Year	3. Time of Death 0 7.05	h M
	/Medic	cal	4a. Facility Name (If not institution,	give street and number)	Con		or Location of Deat	March	2 2 4c. County	of Death	0 7.0)	
	C.XdIIIII	iei	Baltimore VA	Medical, 10 h	1 Greens		imore	City		N/A		
	uneral		,	Sex 7. Age ((In yrs. last birtl	Months Dave			Year)	Cour	place (State or Fore	_
	irector		236-62-0022 Usual Residence of Decedent	1341 201	73 Y	rs.		Sep. 8,	1931	Wes	t´´Virgini	la
yland	MOL THE		10a. State 10b. County	1	Ioc. City, Town	or Location				1	0d. Inside City Lim	nits
в Маг	infied	ctor	MD N/A			Baltimore					1 X Yes 2 □ I	No
vith th	be no	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?	
eath v	ns 234 must	Funeral Director	1332 Glyndon Av	enue 12. Was Decedent Evo	er in U.S.		1223 Hispanic Origin? (S		nited		es Indian.	
atter d	or Item		1 ☐ Never Married 2 🗓 Married	Armed Forces? d 1 XYes 2 No		13. Was Decedent of If Yes, specify Cub		to Rican, etc.)	Blac	k, White,	etc.	
Sours .	urel, o	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	200	1 ☐ Yes 2 🛣 No			Specify	: \	Vhite	
n 72 h	"nati	Completed	15. Decedent's (Specify only highest	grade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	rking 1	6b. Kind of Bu	siness/In	dustry	
d withi	rthen	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Mechanic	,		Mach	iner	Į.	
a file	d othe	Bec	17. Father's Name (First, Middle, La	ist)			18. Mother's Nar	ne (First, Middle, M				
y la	narke netic e	5	William G. Conr.				Minnie	The state of the s				
d 2 sh	7 is n		19a. Informant's Name/Relationship			Mailing Address (Street					Code)	
S 1 an	item 2 other	Lie	Virginia Peggs 20a. Method of Disposition	Sister		14 Werworth Disposition (Name of r, crematory or other pla			MD 21 0c. Location -		wn, State	
rmit. Pages	nt: If		Burial 2 ☐ Cremation 3 4 ☐ Ponation 5 ☐ Other (Spe	Zanellioval libili State		Family Ceme		-2005 G	ilmor (Count	y, W.VA	
armit.	Comparison or from 27 is marked other then "naturel", or items 23a or 28e-f show many injury or other treumetic event, the Medical Exacting must be notified at once.		21. Signiture of Funeral Service Service			Name and Addre			eral H	ome,	Inc.	
3 6	5583		COM MING V	2 /W/		1328 Sulph	nur Sprin	g Rd., Ar	butus,		21227	- 1
			23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line.			ng, such as cardiad	or respiratory arres	st,		Approximate Interval Between Onset and Death	
_	/sician ledical		disease or condition resulting in death)	Due to (or as a c		Failure				-1	16 Day	>
Exa	aminer		Conventints link one distance	500 10 (01 23 2 0	5011504401100 0	·//-						
P		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury	Due to (or as a o	consequence o	f):						
xecute	and I-trans	Examine	that initiated events resulting in death) Last	c Due to (or as a c	consequence o	T):						
9 be ey	physician and the burial-transit	dical E		ď	·	,						
difficat	O &	Medic	IE SENALS									
ath cer	been signed by the attending pt should be detached tor use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth 2[Fetal death	3 ☐Ectopic pregnanc	y		23d. Date Mor	e of delive	ry Day Year	
he de	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tin 9□Unknown	ne of death	5 Other (specify)					24,	
that	ned by s deta	by Ph	Part II. Other significant condition	s contributing to death but i	not resulting in	the underlying cause gr	ven in Part I.	23e. Did toba	icco use contr	ibute to th	e cause of death?	
require	en sig	ed b	Hypertensi	on, Di	abet	es Mell	1:tus	1 ☐ Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknow	wn
aw s	as be	Completed	Atrial F	-ibr.llat	ion		·	24a. Was an autopsy	p	rior to cor	osy findings availab	ble of
The	certificate has rector, page 2	Con						performe	e d ? d	eath?	2. No	
VILAI sicien: 1	certifi	o Be	25. Was case referred to medical examiner?	Hospital:	2 C F B / O - +	Ottoo Ottoo	200	ath (Check only one,				
P Phy	er this eral d	H	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Ti	me of 28c, Inju	4 Li Nursing H	lome 5 Residen 28d. Describe how			"	
Sndin	or: Aft he fun	atlo	1 Natural 5 Pending 2 Accident investigat	tion	dat/ III		Yes 2 □No					
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed	mining a rough and about To the Funerel Director: After this certificate has completely tilled in by the funeral director, page 2	Certification:	3 Suicide 6 Could no 4 Homicide determine		- At home, fam (Specify)	m, street, factory, office		28f. Location (Stre City or Town,		er or Rura	Route Number,	
spitel	tilled		29a. Certifier 1 Certifying	Physician: To the best of r	my knowledge,	death occurred at the ti	me, date and place	, and due to the cau	ise(s) and mar	ner as st	ated.	
he Ho	he Fui	edical	(Check only 2 Medical Ex	(aminer: On the basis of ex and manner states	kamination and	or investigation, in my	opinion, death occu	rred at the time, dat	e and place, a	nd due to	the cause(s)	
Tot	Tot	Σ	29b. Signature and title of oertifier	7 -1	70	29c. Licens	se number		d. Date signed		-	
				0	112		1354	, ,	Tarch	2	, 2005	
	5		30. Name and address of person wh	no completed cause of deal	1 1	reenc	+. B	altimor	e M	D	21201	
41	Sta		31. Date filed (Month, Day/Year)	32. Registrar's		, <u>, , , , , , , , , , , , , , , , , , </u>						
	Registr	ar	MAR 1 0 200	15 Maria	K A	34/28						

			1 - For State Registrar		rtment of Health and M tificate of Death		146/11 6007
	•		Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medio		laevis.	L. Coles			28, 2005 20:28 M
	Examir		4a. Facility Name (If not institution, give street ar	id number)	4b. City, Town, or Location of Death		4c. County of Death
			Johns Hopkins Hospita		Baltimore If Under 1 Year If Under 24 Hrs.		
П	Funeral Director	Н	5. Social Security Number 6. Sex 110-56-4978 1. DM 20	7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) 171 ARY Land
	p ,		Usual Residence of Decedent			7 7 3	DI Tiney Server
	Aaryla r shov	ក	10a. State 10b. County	10c. City, Town or Loc	more		10d. Inside City Limits 1
	the N	Director	10e. Street and Number	· IOCLT I	10f. Zip Code	100.0	Citizen of What Country?
	th with	al Di	3902 Chester	field Ave.	21213	109.	USA
215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Exertinet be trufflied at	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2.ETNo	Yes 2 INO Specify:	ocify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLack
5-0	72 hours natural', incel Exe	sted	15. Decedent's Education (Specify only highest grade comple	16a. Decede	ent's Usual Occupation and of work done during most of working	16b.	Kind of Business/Industry
121	.⊆ - 2	Completed by		life. D	ind or work done during most of working of NOT use retired) Self Employed		one Improvement
d 21	e filed with I Hygiene. other thei	e Co	17. Father's Name (First, Middle, Last)	4		(First, Middle, Maide	
Maryland	hould be id Mental marked o matic eve	To Be	ALvin R. Coles	>	Anna		chinson
lary	2 shou and N is mai		19a. Informant's Name/Relationship (Type, Print		Address (Street and Number or Rura	l Route Number, City	
	and sealth m 27			other 390;	The second secon		3040.Md. 21213
Baltimore,	0 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal		atory or other place)	1 -	Location - City or Town, State
IĦ			`4 □ Donation 5 □ Other (Specify) 21. Signatur & Fyreral Service Licens	Fing M	emorial PK 3/5 Name and Address of Facility 162	105 No	odlawing, Mi)
Ba	permit. Departr Importe any inji		I Geffry Mil	les W	iller Metropolitan	-6 6 0	C. 21213
			23a. Part1. Enter the disease or complications to shock, or heart failure. Zist only one cause	hat caused the death. Do not enter			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	iplications of 1	sunt force he		Onset and Death
	/Medical- Examiner		resulting in death)	e to (or as a consequence of):		,	
	- 7	er	Sequentially list conditions, bb.	e to (or se a noneaquenca of):			
	cuted nd ransit	Examiner	Tary, Jacobig to Inmodiate cause. Enter Underlying Cause (Disease or injury that initiated events				
, 0,	cate be executed physician and the burial-transit	Ex	resulting in death) Last Du	e to (or as a consequence of):			
8760,	cate b	dical	d				
0 × 6	death certific attending p	/Me	IF FEMALE: 23c. If yes	s, outcome of pregnancy			CONT. Data of deliver
.O. Box	0 0 0	Physician/Me	in the past 12 months?	ive birth 2 Fetal death 3 E	ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
s, D	requires that the reen signed by th hould be detache	by P	Part II. Other significant conditions contributing	to death but not resulting in the und	ferlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	w requir	eted				1 ☐ Yes 2	No 3 Probably 4 Unknown
al Record	The lay ate has page 2	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? o 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 ☐ No Hospital:	XXInpatient 2 ☐ ER/Outpatient	26. Place of Death Other: 4 Nursing Horn		0.5104(0.57)
υof		T iu	27. Manner of Death 28a. D	Date of Injury 28b. Time of	28c. Injury at 2	e 5 Residence 8d. Describe how inju	ry occurred ;
sior	Attanding In death. sctor: After by the funer	catic	2 Accident investigation 2	Carlot Control	Work? 1 □ Yes 2 1 No	subject u	ias assulted
Division	or Attan after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. F 4 ☐ Homicide determined 28e. F	Place of Injury - At home, farm, stree building, etc. (Specify)		8f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e) 2235 E. North AVE
_	te Hospitel on 24 hours afte Funeral Dietely filled is		29a. Certifier 1 ☐ Certifying Physician: To	o the hest of my knowledge death of	occurred at the time, date and place, as	Battimore	mb
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 26 Medical Examiner: On t	he basis of examination and/or inversance stated.	stigation, in my opinion, death occurre	d at the time, date an	d place, and due to the cause(s)
	To the within 2. To the I complet	ž	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)
,	1		hing hi, mid		OCME	Mar	ch 1, 2005
	K		30. Name and address of person who completed			Raltimore	e, Maryland 21201
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature		TOT CTHOLE	, rarytanu 21201
: 6	Registr	ar	MAR 1 0 2005	was to free			

		1 - For State Registrar	State of Maryl	land / Depa <i>Cer</i>	rtment of F tificate of	lealth and M <i>Death</i>		ene2 () ()	5 07982
Phy	ysician	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	ledical	John Coutinho	6.4				March 4,	2005	3:35 A M
Ex	amine	4a. Facility Name (If not institution, give Oakcrest Village		c	Baltimo	r Location of Death		4c. County of Daltin	
Fun		5. Social Security Number 6. Se 15	The off	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 8/9/191		Birthplace (State or Foreign Country)
Direc	ctor	Usual Residence of Decedent	85 AM 2LJF) 113.			8/9/191	3 F	Portugal
ATM Marylan		MD Baltimo:		City, Town or Loc					10d. Inside City Limits
Z86-1	all locate	MD Baltimo:	re	Parkvil1	e 10f. Zip Code			-	1 ☐ Yes 2 ☐ No
Se or	i d	8800 Walther Blv	d. Apt. 3410)	2123	4	100	U.S.A.	•
3/4/6 5 35 6 6 6 6 6 6 6 6 6 6	Naminer must be notified by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces? 1	If	_	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc.
$\int 4/0 \le$ 5-0036 72 hours afternonturel; or the	ed by	3 Widowed 4 Divorced	Year or Dates:		Yes 2 No	Specify:	1.2		White
21215- ad within 72 giene.	r, the Madical E	(Specify only highest grad	College (1-4or 5+)	(Give F		during most of worki	ing 16	b. Kind of Busin	ess/industry
N = = -	ent, E	17. Father's Name (First, Middle, Last)	4	Mec	nanical	Engineer 18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland 3	other treumetic event,	Joaquim Coutinho				Louise	Valet		
Mary 12 sho	Le num	19a. Informant's Name/Relationship (T) Alan Coutinho/So				and Number or Rura			te, Zip Code)
ore, M	other	20a. Method of Disposition		b. Place of Dispos	ition (Name of	Way Westc		110 c. Location - City	or Town State
		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Ceder Hi	atory or other plac 11 Cemete				, Maryland
Baltimore, Baltimore, Permit. Pages 1 and Department of Health Importent: If item 21	ny inju	21. Signature of Funeral Service Licens		L 22.	Name and Addres	ss of Facility Mil.	ler-Dippe	1 Funer	al Home Inc.
0	65 CI	23a Part 1 Enter the disease or compl	ications that caused the d	() 6	415 Bela:	ir Road B	altimore,	Maryla Maryla	nd 21206 Approximate
Pnysic	iao :	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	1				•	Interval Between Onset and Death
/Medi Exami	cal	disease or condition resulting in death)	Due to (or as a con	sequence of):	cell	canci	~		
LAdilli	•	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con:	sequence of):					
(degree of	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,						
\$8760, icate be executed physician and	I Exa	resulting in death) Last	Due to (or as a con-	sequence of):					
68760, ificate be ex	as the bur		J						
Box 6	an/Me	23b. Was decedent pregnant	3c. If yes, outcome of pre		ectopic pregnancy			23d. Date of	
Division of Vital Records, P.O. Box 68760, the Hospitel or Attending Physicien: The law requires that the death certificate be execut that Standard Brector: After this certificate has been signed by the attending physician and the standard brector: After this certificate has been signed by the attending physician and	be detached for use by Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o		Other (specify)			Month	Day Year
Division of Vital Records, P.O. to Attending Physicien: The law requires that the diatter death. Director: After this certificate has been signed by the	by P	Part II. Other significent conditions cor	ntributing to death but not	resulting in the unc	lerlying cause give	on in Part I.			e to the cause of death?
Cord requi	eted	acuft +	monic	rena	land	une	1 Tes		Probably 4 Dunknown
Re(Completed						24a. Was an autopsy performed	prior death	
ien: Tital	Be C	25. Was case referred to medical examiner?				26. Place of Death	1 Yes 2 Check only one)	MO 1 1 Y	∕es 2□No
of V Physic	Tol	1 Yes 2 No		ER/Outpatient 28b. Time of	3□ DOA Othe	4 gradising non	ne 5 🗆 Residenci		ipecify)
on Inding	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) Injury	28c. Injury Work M 1 \(\sum \)	at 2 ? ′es 2 ⊡No	8d. Describe how i	injury occurred	
ivis or Attenter ter des irector	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, stree	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or	Rural Route Number,
pitel cours af	Se	29a. Certifier 1 Certifying Phys	sician: To the best of my l	knowledge, death		a data and place a			
Division of Vital Records, F To the Hospitel or Attending Physicien: The law requires the within 24 hours after death.	Medical	(Check only 2 Medicel Exeminate)	ner: On the basis of exam and manner stated.	ination and/or inve	stigation, in my op	e, date and place, a inion, death occurre	nd due to the cause od at the time, date	e(s) and manner and place, and c	as stated. Jue to the cause(s)
To the trought	×	29b. Signature and title of certifier	/	D W	29c. Lice se	number	29d.	Date signed (Mo	onth, Day, Year)
nM	1	30 Name and address of person who co	mpleted cause of death/l	Item 23a) (Type Pi	int)	mog	_	3/7/	07
150		Bruce Gruna	itur ill	8800	W. St.	un Bbil	(and	conlled	YE 21534
Rec	State gistrar	31. Date filed (Month, Day, Year) MAD 1 0 2005	2. Registrar's Sig	gnature	2				

			1 - For Registrar	State	of Maryla	•		nt of H te of L		nd Me	ental Hygie Reg	ene () ()5	07983
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)	-					2	2. Date of Death Month	Day	Year	3. Time of Death
F	Physici /Medic		Elea	nor M.	Dalfo	nzo					March		2005	12:02 A ^M
	Examin		4a. Facility Name (If not institution, g	give street and r	number)		4b. City	, Town, or	Location of [Death		4c. Count	y of Death	
			Renaissance						nsvil			Baltimore		
	Funeral			.Sex 1 ☐ M 2 💢 F		s. last birthday) / Yrs.	Months Months	or 1 Year Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Day, Y			olece (State or Foreign ntry)
	Director		213-18-1211 Usual Residence of Decedent		8	4 Yrs.					CT 23,	1920	Maı	cyland
	and wo		10a. State 10b. County		10c. (City, Town or Lo	cation						1	10d. Inside City Limits
	f sho	ō	Maryland Balt	imore				Co	tonsv	.:11				1 ☐ Yes 2 X No
	the 1	Director	10e. Street and Number	THOLE		_	10f. Z	ip Code	LOHSV			. Citizen of	Whal Cour	ntry?
	3a or		413 Westsid	e Boul	evard			21	228			US	* A	
	be filed within 72 hours after death with the Maryland all Hygiene. Id Hygiene. Id other than "naturel", or Items 23a or 28a-f show other than "naturel", or Items 23a or 28a-f show event, the Medical Exorifier must be notified at	Funeral	11. Marital Status	12. Was De	ecedent Ever in	U.S. 13.	Was Dec			n? (Spec	ify Yes or No- ican, etc.)	14. Ra	ce - Americ	
	after or Ite	F	1 Never Married 2 Married	d 1 ☐ Yes	Forces? s 2 X No		_			Puerto H	ican, etc.)		ck, White,	etc.
2-003p	hours after turel', or Ite	l by	3 XWidowed 4 ☐ Divorced	If Yes, (Year or	Dates:		1 🗌 Yes	2 K I NO	Specify:			Specif	w: Wh	nite
ה ה	e filed within 72 hours it Hygiene. other than "naturel", vent, the Medical Exe	Completed	15. Decedent's (Specify only highest)	Education	d)	16a. Deced	dent's Us	ual Occupa	tion uring most o	of working	16	b. Kind of B	Business/In	dustry
Z	within 72 ene. than "nai	npi	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. I	DO NOT	use retired)	_					
V	filed w Hygiei other tl		1.2 17. Father's Name (First, Middle, La	-41		0	111	ce C		- No	(First, Middle, Ma			versity
and	ild be fi lental H ked ot Ic ever	Be		_	1								,	
<u> </u>	2 should be and Mental is marked of aumatic ev	ို	August Mago		Kas	10h Mailie	an Addra	Ctroot o			ephine			
<u> </u>	nd 2 st alth and 27 is r r traur				h +		•							and 10m 5
a)	the state of the s		JoAnn D. Hixon	1/ Daugi		. Place of Dispo	sition (Na	ame of	-	VQ.	, Cator	OSV11	Le,	MD 21228
Ď	Pages nent of int: If it iry or o		1 ☐ Burial 2 X Cremation 3		m State	cemetery, cren			′ I	10.1				
Saltimor	artme orteni njury		' 4 ☐ Donation 5 ☐ Other (Spe 21. Signatur 3 ☐ Full eral Service Lig		ME	etro Cre							1mor	e, MD
מ	permit. Pages Department of the Importent: If ite any injury or of once.		Edward A	Gregor	rchik	M 3	ac N	abb l	uner	al :	Home,	Inc.	-111	. MD 2122
			23a. Part1. Enter the disease, or of	implications that	t caused the de								1116	Approximate
	Dhysisian		shock, or heart failure. List on Immediate Cause (Final	_										Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		to (or as a conse	equence of):								Years
	Examiner				, , , , , , , , , , , , , , , , , , , ,	,								
		Jer	Sequentially list conditions, if any, leading to immediate	Due t	o (or as a conse	equence of):								
V	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
Ď	e exe ian al ırial-t		resulting in death) Last	Due to	o (or as a conse	equence of):								
0/0 0/0	cate be executed physician and s the burial-transit	dical		d							·-			
0		a) i	IF FEMALE:									1		
X O D	death ce le attend ad for us	Ician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome of preg birth 2 Fe	tal death 3		pregnancy					ite of delive onth	ory Day Year
- 5	the de	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∟Pre- 9□ Unk	gnant at time of known	death 5	Other (s	pecify)						,
	that the death certif ed by the attending detached for use a	م ا	Part II. Other significant conditions	s contributing to	death but not re	esulting in the ur	nderlvina	cause give	n in Part I.		23e. Did tobac	co use conf	tribute to th	ne cause of death?
g,	The law requires that ate has been signed b page 2 should be deta	d b		•		•	, ,				1 🗆 Yes	2 🗆 No	3 ☐ Prob	ably 4 Minknown
2029	v requ been shoul	ompieted									24a. Was an	24b	Wasa auto	psy findings available
ĕ	has be 2	mp									autopsy performe		prior to cor death?	mpletion of cause of
		0	OS Microsoft and to modical				-				1 Yes 2	No	1 🗌 Yes	2DNo
N I G	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	∃Inpatient 2[☐ ER/Outpatien	t 3 🗆 D	Othe	~		<i>Check only one)</i> e 5 ☐ Residend	- C - Oth	os /Casak	
	ding Phys h. After this funeral dir	H-	27. Manner of Death	28a. Dat	te of Injury	28b. Time of		28c. Injury Work		-	d. Describe how			7)
0	th: Afte	tion	1 Natural 5 Pending 2 Accident investigat		onth, Day Year)	Injury	М		? es 2∐No					
JIVISION	Attending in death. ector: After by the fune.	ertification:	3 Suicide 6 Could not	286. Plat	ce of Injury - At	home, farm, stre	eet, facto	ry, office		28	of Location (Street		er or Rura	I Route Number,
5	s efte	Cert	4 [] Homicide	bull	lding, etc. (Spec	ury)					City or Town, S	olale)		
	lospit hour unera	edicai (29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the	he best of my ki	nowledge, death	occurred vestigation	at the time	e, date and p	place, an	d due to the caus	se(s) and ma	anner as st	ated.
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medi	one) 29b. Signature and title of certifier	and ma	anner stated.			c. License				Date signe		
	8 7 8 7		Man 1/1	_ /										
			30. Name and address of person wh	no completed ca	use of death /ltr	em 23a) (Type	Print\	309	189		11/	over	7 09	2000
	6		Mula M CCUrb		M	711 0	Mai.	dan	Chai	ina	Lo Co	the	line	7.
	Sta	te	31. Date filed (Month, Day, Year)	32/	legistrar's Sign	nature		uye 1.1		nee.		~~~		
	Registr	_	MAKIU	Z005 A	Theban .	W. An	BARA	P						

			1- For Amend Item 28f per ME, G841,	epartment of Health and M	•	•
				Certificate of Death		No.2005 07001
н	Physici	an	1. Decedent's Name (First, Middle, Last)			Day Year
3	/Medio		Dennis Timothy Dashner 4a. Facility Name (If not institution, give street and number)	4b. City Town, or Location of Death	Janese, 31	2005 2/4 7 M 4c County of Death
	Examin	er	your Ches make Medical Center	Pal Olas		Ho. O. D
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
н	Director		212-52-0995 ¹₹M 2□F 51 Y	s. Months Days Hours Min.	Apr. 2, 1	953 Maryland
	pug A		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Aaryla f sho	ō				1 ☐ Yes 2 👿 No
	28a-	rect	Maryland Harford 10e. Street and Number	Street 10f. Zip Code	10g.	Citizen of What Country?
	3a or	Funeral Director	3351 Grier Nursery Road	21154		u.s.A.
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or It	y Fu	1 Never Married 2 Married 1 Tyes 2 No	1 ☐ Yes 2 🕱 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify
5-0036	72 hours after death with the Maryland natural', or Hems 23a or 28a-f show Jisal Evanthar must be notified at	q pe	3 ☐ Widowed 4 🕱 Divorced Year or Dates: 15. Decedent's Education 16a. □	Decedent's Usual Occupation	16h	. Kind of Business/Industry
5	n "na	Completed by	(Specify only highest grade completed) (Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work ife. DO NOT use retired)	ing	. Kind of businessing
2121	d within giene. or then "	Com	Elementary/Secondary (0-12) 12th Grade H	orse Jockey	H	orse Racing
	be filed tal Hygie d other event, t	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	den Sumame)
yla	Meni Meni Marke Marke	2		Concet		ere
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-1 show any higher or other traumatic event, the Medical Examinat must be notified at any higher or other traumatic event, the Medical			Mailing Address (Street and Number or Rui 51 Grier Nursery Rd		
	1 and Healt Iem 2		20a. Method of Disposition 20b. Place of 5			Location - City or Town, State
ΘĽ	Pages nent of int: If II		I A Bunar 2 Cremation 3 Removal from State	r Mem'l Gardens 2/4,	12005 Be	P Air Maruland
Baltimore,	mit. F partm. portar / Injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sch		
ä	Departiment of the particular		Man	9705 Belair Rd.,		
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	cation		Onset and Death
	/Medical Examiner		Due to (or as y consequence of	1. 6	6	
3		į.	Sequentially list conditions, That it is a consequence of Due to (or as a consequence of	notice pois	neng	
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	/		
9,	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
3760	e ys	lical	d.			
x 68	certifica Iding ph Ise as th	Med	IF FEMALE:			
Вох	death or e attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	the de	iysic	1 Yes 2 No 9 Unknown 9 Unknown	3 Other (specify)		
<u>α</u>	The law requires that the te has been signed by the bage 2 should be detache	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
rds	w requires been sig should b	ed b	None		1 🗀 Yes	2 No 3 Probably 4 ☐Unknown
Records,	aw re	piet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
B		Completed			performed 1 ☐ Yes 2 【	? death?
Vital	ician: Thi certificate ector, pag	Be	25. Was case referred to medical examiner?	0.0	th (Check only one)	
of	Physician: this certific ral director,	5	1 Yes 2 No Hospital: 1 Inpatient ★ER/Outp		ome 5 Residence	6 Other (Specify)
on	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Inj	ne of uny at work? UNIK ^M 28c. Injury at work? 1 □ Yes 2 ☒ No	C. D.A.	P
Division	Attending r death. • ctor: After y the fune	fica	3 Suicide 6 Could not be 78e. Place of Injury - At home, fam		28f. Location (Street	and Number or Rural Route Number, ate) MD
Ö	s afte	Cert	4 Homicide determined building, etc. (Specify)			r Nursery Rd., Street
	Hospitel 24 hours a Funeral I	cai	29a. Certifier 1 □ Certifying Physician: To the best of my knowledge, (Check only Medical Examiner: On the basis of examination and	death occurred at the time, date and place,	and due to the cause	e(s) and manner as stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification;	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	To To	_	29b. Signature and title of certifier	IN ICO TEL	1	7 3
	C		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Printly	set	may & Lees
	D		BERNARD J. VYKNA, MO. AME	7018 HOLABIRO 1	VE BAL	TO Md 21222
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,		
	Registr	ar	MAR 0 8 2005	No. 1		

			State of Maryland / Department of Health and M 1 - State of Maryland / Department of Health and M Certificate of Death	lental Hygie	2005 07005
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year 3. Time of Death 2005 1.40H M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bulling Power of Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 22 Hrs.	MOLE 8. Date of Birth	4c. County of Death 9. Birthplace (State or Foreign Country)
	Director		217-12-3190 1⊅M 2□F 80 Yrs. Months Days Hours Min. Usual Residence of Decedent	(Month, Day, Ye 9-30-2	MARYLAND
	Be-f show	ctor	10a. State 10b. County 10c. City, Town or Location BALTIMORE Middle River		10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23e or 2	Funeral Director	10e. Street and Number 10f. Zip Code 21220	10g.	Citizen of What Country?
920	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show disal Ezandrair out be indiffed at	þ	If Yes, Give 1 Yes 2 kg No Specify: Year or Dates:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Whi
21215-0036	within ane. then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Iffe. DO NOT use retired)	ng 16b	Rind of Business/Industry Rolling Ce City
Maryland 2		To Be C	17. Father's Name (First, Middle, Last)	(First, Middle, Maid	on Sumame)
-	es 1 and 2 sh of Health and f Item 27 Is m r other traum		1 Burial 2 Cremation 3 Removal from State	Middle ate 200	Location - City or Town, State
Baltimore	permit. Pag Department Important: I any njury o		21. Signature of Funeral Service Licensee		arrison MD
	Physician /Medical		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. AUCUNCINOMA I		Approximate Interval Between Onset and Death 2 10 10 10 10 10 10 10 10 10
8760,	Examiner	licai Examiner		<i>V</i>	3 years
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	hysician/Medi			23d. Date of delivery Month Day Year
ds, P.	uires that signed b d be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 \(\sum \text{No} \) No 3 \(\sum \text{Probably} \) Probably 4 \(\sum \text{Unknown} \)
	The ate h page	Completed		24a. Was an autopsy performed 1 Yes 2	
of	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	tion; To Be	examiner? 1 Yes 2X No		6 □Other (Specify) njury occurred
Division	i Si fe	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Ai within 24 hours after or To the Funerel Direct completely filled in by	dicai	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
	5+1		30. Name and a press of person who impleted cause of death (Item 23a) (Type, Print) AUGUSTIN CHYU, 3700 & 60ch Rayan Bland, Baltima	Ma Ca	77/03
	Sta Registr	_	23 Data tilad (Manth Day Yoar)	Ju, 101	V 1110

			For State	State	of Maryla		artment of F		d Mental Hy	-	11115	070	86	
			Registrar 1. Decedent's Name (First, Middle	e, Last)			inouto or	Death	2. Date of De	Reg. No."		3. Time of E	Death	
	Physici		Bessie Lee Dox	czon					March	7 200	Year	3:10 F		
	/Medio Examir		4a. Facility Name (If not institution		number)		4b. City, Town, o	r Location of D		County of Death	1			
			Gilchrist				Towson			Baltimore				
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2√2 F		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Vin. (Month, Da	Birth 9 Birtholace (State or Foreign				
-	Director		214-01-6937 Usual Residence of Decedent	X	87	Yrs.				1 1917 MD				
	land ow		10a. State 10b. County		10c. (City, Town or Le	ocation					10d. Inside City	/ Limits	
	Mary -fsh	ţ	MD Balti	more		Glen	Arm					1 🗌 Yes	2 No	
	within 72 hours after deeth with the Maryland liene. Than "natural", or Items 23e or 28e-f show the Medical Examana invalor indified at	Directo	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou			
	th wit		11630 Glen Arn	n Rd.			21057				USA			
	eep swe	Funeral	11. Marital Status	12. Was D	ecedent Ever in Forces?	U.S. 13.		lispanic Origin	? (Specify Yes or No		4. Race - Amer Black, White			
Š	or It	by F.	1 Never Married 2 Marr	ied 1 ⊟Ye If Yes,	S 2 No Give		1 ☐ Yes 2 ☐ No	Specify:		9				
2-003b	hours after turs!', or Ite	q p	3 Widowed 4 Divorced		r Dates:			ation.			VV	hite		
ဂ်	in 72	Completed	(Specify only higher			(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of d)	working	16b. Kind	d of Business/l	ndustry		
7	within jiene. r than "	E O	Elementary/Secondary (0-12)		e (1-4or 5+) /a		kkeeper	•		Incu	rance			
ğ	e filed Hyg oths	Be C	17. Father's Name (First, Middle,		1 =		киссро	18. Mother's	Name (First, Middle					
<u>a</u>	uld by Menta Irked Ific ev	ToE	Charles Winfiel	d Morris	3			Elsie	May Tall	oot				
<u>a</u>	s 1 and 2 should f Health and Men flem 27 is marke other treumatic	i ,	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street	and Number o	r Rural Route Numb	er, City or	Town, State, Z	p Code)		
∑ .;	and and malth m 27		Patricia Martii	n/daugh	ter	292	Monkton	n Rd.,	Monkton,					
<u> </u>	m 0		20a. Method of Disposition 1 ★ Burial 2 □ Cremation	3 Removal fro	I .	Place of Dispo cemetery, crea	osition (Name of matory or other place	(e)	Date 3 / 10 / 05	20c. Loc	ation - City or T	own, State		
altimor	permit. Page Department a Importent: fi eny injury o		` 4 ☐ Donation 5 ☐ Other (S	pecify)			Valley M	ausolei	ım	Tim	onium,	MD		
ga	Depar Depar Impor eny in		21. Signature of Funeral Service	ensee		2: L	2. Name and Addres	ss of Facility	Home of	Dular	nev Val	lev In	C	
	40300		Michael J. P 23a. Part. Enter the disease, or	lagle		1	0 W. Pad	onia R	d., Timor	nium,	MD 21	093	-	
			SHOCK, OF HEAR TAILUTE. LIST	only one cause of	n each line.	ath. Do not en	er the mode of dyin	ig, such as car	diac or respiratory a	rrest,		Interval Between Onset and De	een	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Gun	gren						week	7411	
	/Medical Examiner		rossing in doubly	Due	to (or as a conse	editence of);	vacula	1 1.	2 4 4 5					
		10	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due	to (or as a conse	aurence off.	7 40.00	- acip	case	-		exercis	9	
1	nsit	ulu u	Cause (Disease or injury	<	(3. 33 3 3 3 3 3 3	,						•		
Ž	be executed siclen and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due	to (or as a conse	equence of):								
2/00	ate be ex hysiclen he buria	dicai												
ğ	law requires that the death certificate es been signed by the attending phys. 2 should be detached for use as the	0		T I										
X D D	es that the death certific, igned by the attending p be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregree birth 2 1 Fe		Ectopic pregnancy	,		23	d. Date of deliv	- /		
	e deal	sicis	in the past 12\months? 1 □ Yes 2 AlNo		egnant at time of		Other (specify)				Month	Day Ye	ar	
л Э	at the	Phy	9 Unknown				-							
Ś	res th iigned be d	by	Part II. Other significant condition	ns contributing to	o death but not re	sulting in the u	nderlying cause give	en in Part I.				he cause of dea		
0	w require been si should b	ted						-	_ 101	res 2 🗆	No 3□Pro	bably 4 Win	known	
ည်	e 2 sl	Completed							24a. Was	sy	prior to co	opsy findings av empletion of cau	ailable use of	
	: The cete h	S							1 ☐ Yes	rmed? 2 No	death?	2□ No		
N II	Physicien: The law r this certificete hes brail ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00	Death (Check only of			1 -		
5	Phy this	. To	1 Yes 2 No 27. Manner of Death		☐ Inpatient 2[ite of Injury	ER/Outpatier		4 🗀 Nursin	g Home 5 Resident			ry haspie	7	
	ding h. After fune	tion	1 Matural 5 ☐ Pendin	g (M	lonth, Day Year)	Injury	Worl	k? Yes 2 □ No	250. 2636/100 1	iow injury	occurred			
DIVISION	Atten deat ctor: y the	ertification:	3 ☐ Suicide 6 ☐ Could	not be	ace of Injury - At	home, farm, str	reet, factory, office		28f. Location (Street and	Number or Run	al Route Numbe	9r.	
5	after after Dira		4 Homicide determ	bu	ilding, etc. (Spec	city)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tou					
	bapiti hours inera y fille	alc	29a. Certifier Certifyin	g Physician: To	the best of my kr	nowledge, deatl	n occurred at the tim	ne, date and pl	lace, and due to the	cause(s) a	nd manner as s	tated.		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only one) /2 Medical	examiner: On the	basis of examination basis of	nation and/or in	vestigation, in my of	pinion, death o	occurred at the time,	date and p	lace, and due t	o the cause(s)		
	To t To t	Σ	29b. Signature and little of certifie	0			29c. License			29d. Date	signed (Month,	Day, Year)		
•			MO	w o	√ 2		N 28	203		mara	4 8 50	03		
	in		30. Name and address of person	who completed co	ause of death (Ite	em 23a) (Type,	Print)		Howe a	11	60			
	10		MIN CM	vers in	V) 660	INC	have S	+ Kal	since &	U) 2	reoy			
	Sta Registr		31. Date filed (Month, Day, Year)	1 0 2005	. Registr's Sign	nature	1. 1.				•			
	negistr	वा	MAR	T A VAID	Secretary 15	D 18	At a State							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

an		npend Item			Dick			2. Date of Dea	ith	Vone	3. Time of Death
cal	de Weekle ble	Theodore		and and	DICK		al anating of Dant	March			02:15 P.
ner	2324 E.	ne (If not institution, g Oliver St	reet and nui	mber)			r Location of Deat .imore	n M	40.0	County of Death	1
	5. Social Secu 219-5	ity Number 6. 0-0294	Sex 1∏ M 2□ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(Year)	9. Birth	nplace (State or Foreig untry)
		ce of Decedent		100 Cib	, Town or Lo	antina					10d. Inside City Limits
ō	10a. State	10b. County	λ	Toc. City		timore					Yes 2 □ No
Director	10e. Street an		<u> </u>			10f. Zip Code		10g. Citizen of What Count			untry?
		E. Oliver	Street			212	13	USA			,
Completed by Funeral	11. Marital Sta		12. Was Dece Armed Fo 1 ☐ Yes	2 No	i	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		rican Indian, o, etc.	
d by	3 🗆 Widow	ed 4 Divorced	If Yes, Gir Year or D	ve ates:		1 ☐ Yes 2X No	Specify:			Specify: B.	lack
ete	(15. Decedent's Specify only highest g	Education rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kin	d of Business/l	ndustry
dmc		Secondary (0-12)	College (1-4or 5+)	me.	Laborei	*			Varies	
Be Co		grade ame (First, Middle, La:	st)					me (First, Middle,	Maiden S	Sumame)	
To B	Ar	Arthur Di			kens		Mary			Lee	
	19a. Informan	200 -									ip Code)
	Regi	nald Dicke	ns B	rother	392	22 Evergr	een Ave.	Baltimo	ore,	Md :	21206
		20a. Method of Disposition 1 Burial 2 (**Cremation 3 Removal from State*) 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cramatory or other place) 3-9-05 Baltimo									Town, State
				State					Ba	ltimore	. Md :
	`4 □Dona		cify)	State	reenmo		3-9	-05		ltimore e, Md.	e, Md: 2J202
	`4 □Dona	ion 5 Other (Spec	cify)	Gr	reenmo	unt Cem.	3–9 ss of Facility	-05 Balti	more		21,202
	4 Dona 21. Signature	ion 5 Other (Spec	ensee mplications that c	Grate Grant	reenmo	unt Cem. 2. Name and Addre March F.I	3-9 ss of Facility	-05 Balti 1101 E	more I. No	e, Md.	2J.202 Approximate Interval Between
	4 Dona 21. Signature	of Funeral Service Lic of Funeral Service Lic atter the disease, or hear failure. List on use (Final ddition	ensee mplications that cly one cause on e	Graused the death	n. Do not ent	unt Cem. 2. Name and Addre March F.I	3-9 ss of Facility 1. East g, such as cardia	Balti 1101 E	more I. No	e, Md.	2J.202
	21. Signature 23a. Part1. Eshock, o Immediate Cadisease or coresulting in de	on 5 Other (Special Service Lice Lice Lice Lice Lice Lice Lice L	ensee mplications that componence cause on e My pert Due to	caused the death each line. ensive (or as a consequence of the ensive o	n. Do not ent Intractuence of):	unt Cem. 2. Name and Addre March F.I ter the mode of dyin	3-9 ss of Facility 1. East g, such as cardia	Balti 1101 E	more I. No	e, Md.	2J.202 Approximate Interval Between
iner	21. Signature 23a. Part1. Eshock, o Immediate Cadisease or coresulting in de	on 5 Other (Special Service Lice Lice Lice Lice Lice Lice Lice L	ensee mplications that componence cause on e My pert Due to	Grand Grand	n. Do not ent Intractuence of):	unt Cem. 2. Name and Addre March F.I ter the mode of dyin	3-9 ss of Facility 1. East g, such as cardia	Balti 1101 E	more I. No	e, Md.	2J.202 Approximate Interval Between
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ai Examiner	23a. Part1. Eighock, o Immediate Cadisease or coresulting in de Sequentially lift any, leading cause. Lifter Cause (Disea, that initiated et	on 5 Other (Special Control of Funeral Service Lice of Funeral Service Lice of Funeral failure. List on use (Final addition ath) st conditions, to immediate underlying se or injury vents	mplications that can be seen to b	caused the death each line. ensive (or as a consequence of the ensive o	n. Do not ent Intractuence of): Juence of):	unt Cem. 2. Name and Addre March F.I ter the mode of dyin	3-9 ss of Facility 1. East g, such as cardia	Balti 1101 E	more I. No	e, Md.	2J.202 Approximate Interval Between
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State

Registrar

31. Date filed (Month, Day, Year) MAR 10 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

OCME

March 3, 2005

			1 = For State Registrar	State of N	Maryland A		artment of F		and Me		ene () ()5	07988
	Physicia	an	1. Decedent's Name (First, Middle, L Mary H. Dougla	-						2. Date of Death Month March 1	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g		or)		4b. City, Town, o	r Location o		March 1	4c. County	of Death	11:30 PM
	Examin	eı	Friends Nursin		,		Olney				Mont		
	Funeral		Social Security Number 6.		Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under:	24 Hrs. 8	B. Date of Birth (Month, Day,		<u> </u>	place (State or Foreign intry)
	Director		195-32-0372	1□M 2∏F	99	Yrs.	WOTHIS Days	110013	S	ept 13,	1905	Pen	nsylvania
	and	1	Usuel Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
	Manyl f sho	jo	MD Montgon	nery		Sand	y Spring						1 □ Yes 2X No
	r 28a	rec	10e. Street and Number				10f. Zip Code			10	g. Citizen of \	What Cou	ntry?
	h with	Funeral Director	17310 Quaker Las	ne				20860	1		USA		
	ams a	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. \	Was Decedent of H	lispanic Orig	gin? (Speci	ity Yes or No-		e - Ameri k, White,	can Indian,
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ∑	No		I□Yes 2X No	Specify:	,		/: whi		
Ö	hours tural',	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates		6a. Decedent's Usual Occupation							
5	in 72 "na" r	ojete	(Specify only highest g	rade completed)	o completed) (Give			during most d)	of working	, ''	6b. Kind of B	usiness/ir	ndustry unk
212	yiene. r thau	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)		social v	vorker	•				
힏	a filed al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, La					18. Mothe	r's Name (First, Middle, Ma	aiden Suman	10)	
<u>yla</u>	should be filed within 72 hours after death with the Maryland and Mental Hyglene. In marked other than "natural", or Itams 23a or 28a-f show umatic event, the Madical Examiliar has be could at	2	Henry Rhea Do	ouglas					Ethe1	Jones			
Maryland 21215-0036	d 2 sho th and 7 Is mu traum		19a. Informant's Name/Relationship Jane McCallis				ig Address (Street 1 N. Sher						60660
ē,	is 1 and 2 of Health a item 27 Is other trau		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of	- 1	Dai		Oc. Location -		
Ю Ш	Pages ent of nt: If i			1 Burial 2 Cremation 3 Removal from State 2 Donation 5 Other (Specify)									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than. "natural", or itams 23a or 28a-f show any injury or other traumatic event, If a Maribal Examiner mast be chillised at once.		21. Signatur Fora Sivice Lice Rona N	4 ☑Donation 5 □Other (Specify) Signatur Feral Styles Licensae Ronal S. Wade Wade Ronal S. Wade Baltimore, MD							Baltim	ore :	Street
			23a. Part 1 Enter the disease, or co shock, a heert failure. List on	mplications that caus	ed the death. [Approximate Interval Between
E	Physician	i	Immediate Caus Final disease or condition	^	umenia								Onset and Death
	/Medical		resulting in death)		as a consequen								7
	Examiner	L	Sequentially list conditions,	b. Coven	evy	Disease						le years	
	tad nsit	nine	Sequentially list conditions, if any, leading to immediate Ent. Incompanying Cause (Disease or injury	Due to (or a	as a consequen	ce m;						- 3	
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequen	ce of):						-	
8760,	death certificate be executad e attending physician and od for use as the burial-transit	edicai		d.									
9	rtifical ng phy as th	Aedi	IEEEMALE.										
Вох	eath certific attending p I for use as I	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal de	ath 3	Ectopic pregnancy	,				te of deliventh	ery Day Year
		Physician/M	1 Yes 2 No	4□Pregnant 9□ Unknown	at time of death	n 5□	Other (specify)				1410	1101	Duy Tour
P.O.	that the de ned by the a detached t		Part II. Other significant conditions	contributing to death	but not resultin	ng in the ur	nderlying cause giv	en in Part I.		23e. Did toba	cco use cont	ribute to t	he cause of death?
Division of Vital Records,	law requires that the as been signed by th 2 should be detache	d by								1 🗆 Yes	2 No	3 🗆 Prot	bably 4 □Unknown
00	s beer	Completed								24a. Was an			opsy findings available
Re	e 4 e	mo								autopsy performe	ed? (prior to co death? I 🔲 Yes	ompletion of cause of
ita	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical	9				26. Place	of Death (Check only one			
> >	Physiclan: this certific ral director,	10	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpa	19.55		t 3 DOA Oth	er: 4🗡 Nu	rsing Home	5 🗆 Residen	ce 6 □Oth	er (Specil	fy)
n o	ding P	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending		njury 28 Day Year)	b. Time of Injury	28c. Injur Wor	k?		d. Describe how	injury occuri	ed	
isio	Attending r death. ector: After by the fund	icat	2 Accident investigat 3 Suicide 6 Could not	be an Blace of I	Injuny - At home	farm etr	M 1 eet, factory, office	Yes 2 □ i		f Location (Stre	et and Numb	er or Rur	al Route Number,
Ď	l or Attendate after death Director:	Certification:	4 Homicide determine	building,	etc. (Specify)	, 121111, 3111	edi, raciory, omce		-	City or Town,		or or ribre	ar riodig rearriber,
_	ospita hours ineral y fillec		29a. Certifier 1X Certifying	Physician: To the bes	st of my knowle	dge, death	occurred at the tir	ne, date an	d place, an	d due to the cau	ise(s) and ma	nner as s	stated.
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by tha funaral director.	ledical	one)	aminer: On the basis and manner	or examination stated.	and/or inv			in occurred				
	Vith To 1	Σ	29b. Signature and title of certifier	- 1			29c. Licens				d. Date signe		
F			Devet a				D 47	69 T		100	lavch 4	1 700	3
_			30. Name and address of person who Bennett Morrison	2901 Olney	- Sandy	Spring	Road, 01	ney,	Maryl	and, 20	872		
	Sta Registr	ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature											

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H rtificate of L		- '	giene	05	17989
	Dhamis		Decedent's Name (First, Middle, I	-				2. Date of Dea	ath Day /	Year	3. Time of Death
	Physici /Medio		STANARD	Dor	-Sey			2. Date of Dea	6	2005	1217 M
1	Examir	ner	4a. Facility Name (If not institution, g	give street and number	7)	- 11	Location of Death		4c. County N/A	of Death	
	Funeral Director				ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h v, Year) 2 - 1939	Cour	place (State or Foreign http) Virginia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Maryi -f aho lied a	tor	Maryland Anne A	rundel	Pasader	na					1 ☐ Yes 2 🔀 No
	r 28a	Director	10e. Street and Number	<u> </u>	1 1 1 1 1 1 1	10f. Zip Code			10g. Citizen of \	What Cour	ntry?
	th with		220 Pinewood D	rive		21222			United	Stat	es
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow to Medical Examinatina than Italiad at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	If Vac Give	? INO Army	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ck, White,	
ö	"natural",	ed b	3 Widowed 4 Divorced		1957-1960	dent's Usual Occupa	ation				
21215-0036	be filed within 72 ho ital Hygiene. id other than "natur event, ire Modical	plet	(Specify only highest of Elementary/Secondary (0-12)		(Give	kind of work done d DO NOT use retired;	luring most of work	ing	16b. Kind of B		austry
	filed wit Hygiene other the	Con	12			mber			Plum		
Maryland		Be	17. Father's Name (First, Middle, La	st)			18. Mother's Name Emma Ma	e <i>(Fir</i> st, <i>Middl</i> e, .rie Dun		10)	
ız	should be tand Mental I a marked o tumatic eve	그	Stanard Dorsey 19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a				State. Zin	(Code)
	ロミトラ		Betty J. Dorsey	- Wife	220	Pinewood I	Drive, Pa	sadena,	Maryla	nd 2	21222
altimore,	permit. Pages 1 am Department of Heall Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place of Dispo cemetery, crea Crownsvil	matory or other place	9) March	Date 11 c	20c. Location - rownsvi		wm, State Maryland
Balti	permit. Departm Imports any inju		21. Sign ware of Funeral Pervice Lic	ense	4	Name and Address irkley-Rud 21 Crain	adick Fun Highway	eral Ho	me P.A. en Burn	ie, Í	21061 Maryland
			23a. Part : Enter the disease, or co shock, or heart failure. List on	inplications that cause	ed the death. Do not entline.	ter the mode of dying	, such as cardiac o	or respiratory arr	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a. Tro	umatic	Brain	INW	ry		- 1	Onset and Death DAYS.
	/Medical Examiner		resulting in death)								
	VOICE.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
V	icate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events	c.				w. ?			
, 0,	e exe ian ar urial-t	I Ex	resulting in death) Last	Due to (or a	s a consequence of):		. 2	EXAMINE	R		_
8760	cate b	dlcal		d			- OVED BY W	EDICAL			
9	eath certific attending p	O I	IF FEMALE:	23c. If yes, outcom-	a of pregnancy	TIEICAT	JON MERBUAD		204 0-4		
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live birth	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			Moi	te of delive nth	Day Year
<u>α</u>	es that gned b be deta	by Pt	Part II. Other significant conditions	s contributing to death						ribute to th	e cause of death?
ords	w require been sig should b	ed t	End Stage L	wer dise	22			1 □ Y	es 2□No	3 Proba	ably 4 DUnknown
Vital Records,	The law reate has be page 2 shi	Completed	Gastrointesti	nal blee	<u>d</u> ,			24a. Was a autops perform	med? c	death?	psy findings available inpletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	1			26. Place of Death				
of	S S	P	1 Yes 2 No	Hospital: 1 Inpat			4 Nursing Hor				′)
no	ding I. After fune	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, D.	ay Year) 28b. Time of Injury	Work		28d. Describe ho	ow injury occurr	be	
Division	ten leat tor: the	flca	3 Suicide 6 Could not	ha	ijury - At home, farm, str tc. (Specify)			28f. Location (St	treet and Number	or or Rura	l Route Number,
ā	al or A s after il Dire	Certification:	4 Homicide determine		itc. (Specify)			City or Town	n, State) Newood D		Ve Shore NI) 2122
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical (29a. Certifier Check only 2 Medical Ex	Physician: To the besi aminer: On the basis of and manner s	t of my knowledge, death of examination and/or in tated.	h occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	and due to the ca	ause(s) and ma	nner as sta	ated
	To the To the Comp	Me	29b. Signature and title of certifier	.5		29c. License	number	2	9d. Date signed		
	N		I while	11/2).			15 152		3-6	- 200	5
_	(2	10.2	30. Name and address of person who	J. MD U	MM 28	Print)	t. Balt	inore w	ND 213	101	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0		rar's Signature	bout "					
DH	MU 17 Day 1/2	001	MINN T O	2000	- N. J.						

	, FOr	Department of Health and Mental Hy Certificate of Death	giene		
Physician	Decedent's Name (First, Middle, Last)	2. Date of De Month	aath 3. Time of Death		
/Medical Examiner	Hazel B. Everhart 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
	Morto Armal Hospi	thday) If Under 1 Year If Under 24 Hrs. 8 Date of Bir	Brown Brown !!		
Funeral Director	5. Sociał Security Number 236 – 01 – 8013 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. Illist bird 2 ☑ F 92	thday) If Under 1 Year If Under 24 Hrs. 8 Date of Bir (Month, Days) Hours Min. Dec 1	th Year) 2 9. Birthplace (State or Foreign Country) WV		
land	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits		
e Mary la-f sho lifted a	Maryland Anne Arundel	Pasadena	1 □Yes 2X No		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or titems 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 762 216th Street	10f. Zip Code 21122	10g. Citizen of What Country? USA		
of the death with the tems 23s other must.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Pueno Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.		
036 urs afte Example by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: White		
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours alt bepartment of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural", or nny injury or other traumatic evant. In Medical Examples. To Be Completed by F	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/Industry		
212 ad withi giene. er than t, than	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	Household		
and doe file ental Hy seed oth	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name (First, Middle, Emrna Balleng			
laryla 2 should and Men is marke sumatic	19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or Rural Route Number	er, City or Town, State, Zip Code)		
Ce, IV		62 216th Street, Pasadena, March, 10 Pasadena, March, 10 Pasadena, March, 10	MD 21122 20c. Location - City or Town, State		
Pages ment of ant: If it is ury or or	1 XBurial 2 □ Cremation 3 □ Removal from State Park I	ry, crematory or other place) Heights Cem. March 10 2005	Brunswick, Maryland		
Balti permit. Depart Import any inji	21. Signature of Funeral Service Lucinsee	22. Name and Address of Facility Stalling 3111 Mountain Road, Pasa	gs Funeral Home, P.A. adena, MD 21122		
	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death		
Pnysician /Medical	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the conseque	>~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
Examiner	Sequentially list conditions, if any leading to immediate	I've war T fai	Ilme		
oxecuted in and instrument	Cause. Enter Underlying Cause (Disease or injury that initiated events	y antry the	ge use.		
ox 68760, certificate be executed and use as the burial-transit	resulting in death) Last Due to (or as a consequence of d.	of);			
x 68. Writicate ing phy e as the Medic	IF FEMALE:				
death death of for for sicial	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yes 2 ☐ Yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year		
T 's Egg S	Part II. Other significant conditions contributing to death but not resulting in	,	tobacco use contribute to the cause of death? Yes 2 No 3 Probably		
I Rec The lav ate has page 2		24a. Was autor perfic 1 □ Yes	psy prior to completion of cause of death?		
of Vital of Vital of vital Physician: rthis certifica	25. Was case referred to medical examiner? 1 Yes	26. Place of Death (Check only of stream of Death (Check only of stream of Death (Check only of Stream of Death (Check only of Stream of Death (Check only of Stream of Death (Check only of Stream of Death (Check only of Stream of Death (Check only of Stream of Death (Check only of Stream of Death (Check only of Death (Chec			
on of Sing Physical distribution; To	27. Manner of Death 28a. Date of Injury 28b. 1	Firme of 28c. injury at 28d. Describe I njury Work?	how injury occurred		
Division of tall or attanding P is after death. al Director: After the funers ed in by the funers Certification;	2 \(\bigcap \) Accident investigation 3 \(\bigcap \) Suicide 6 \(\bigcap \) Could not be determined and the determined and the determined are determined.	M 1 ☐ Yes 2 ☐ No Irm, street, factory, office 28f. Location (street)	Street and Number or Rural Route Number,		
Div vital or urs afte rrai Dire lled in t	4 normolde building, etc. (Specify)	City or Tox			
Division of Vita Division of Vita o the Hospital or Attanding Physician: lithin 24 hours after death. o the Funarai Director: After this certificompletely filled in by the funeral director, Medical Certification; To Be	29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge and manner stated.	e, death occurred at the time, date and place, and due to the d/or investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)		
o the common of	29b. Signature and the of certifier	29c. License number) 4 8 00 b	29d. Date signed (Month, Day, Year) 03/07/2005		
Ν	30. Name and address of person who completed cause of death (Item 23a)	(Type Print) from home	Burnit mD		
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hark			

			Please I		iack indelible ink. Ensure A		
			For State	State of Maryland	/ Department of Health and N	iental Hygie	ene 2005 07991
			Registrar		Certificate of Death		. No.
	Physicia	an l	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
4	/Medic	al .	Edith E.	Forsythe		March	03 300) 3.30
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death
			S. Social Security Number 6. Sec	OEL TOSAITA	ast birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M 2K1F 70	Months Days Hours Min.	8. Date of Birth (Month, Day, Y ADY 1 05	1934 Country) PA
			Usual Residence of Decedent	70		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	yland		10a. State 10b. County		, Town or Location	io	10d. Inside City Limits
	Mar ilied	to	Maryland Anne A	rundel	Glen Burr		1 ☐ Yes 2 X No
	th the	ire	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?
	within 72 hours after death with the Maryland ene. Than "nstural", or flems 23a or 28a-f show La Medical Examinar must be invititud at	Completed by Funeral Director	15 Marley Neck I	Road	21060		USA
	ems ems	nei	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or if	Ž.	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 🗖 No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:		Specify: White
21215-0036	hour tural	d be	15. Decedent's Edu	Year or Dates:	16a. Decedent's Usual Occupation	16	Sb. Kind of Business/Industry
5	in 72	olet	(Specify only highest grad	le completed)	(Give kind of work done during most of work life. DO NOT use retired)	king	,
12	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker		Household
b	Hyg other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma	iden Sumame)
lan	Aenta Aenta rked rked	To B	Guy E. Buch	annon	Marga		rteo
Maryland	short s ma		19a. Informant's Name/Relationship (7)		19b. Mailing Address (Street and Number or Ru		
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any righty or other traumatic svant, Ite Medical Examinat must be indiffed at once.		Walter B. Forsythe		1004 Park Place, Balt		
Baltimore,	of He		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F	Removal from State	ace of Disposition (Name of emetery, crematory or other place) March	1 08	oc. Location - City or Town, State
Ë	Pag ment ant: lury c		* 4 □Donation 5 □ Other (Specify,	Gie	n Haven Cemetery 200	, 0	len Burnie, Maryland
3alt	Depart Import sny in		21. Signature of uneral dervice licens	" ALIH	22. Name and Address of Facility S1		
	<u>40</u> = # 0		Muschelf	Hallens	Do not enter the mode of dying, such as cardiac		
			23a. Part / Enter the disease, or comp shock, or heart failure. List only	ne cause on each line.	,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Emy	phy sema (cor	13)	years
	/Medical Examiner			Due to (or as a conseq	nce of):		
		in in	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	uence of):		
	peri	E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				(A)
(~	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):		
760		ल	(d			
68	The law requires that the death certificate at has been signed by the attending physicage 2 should be detached for use as the	by Physician/Medic	15551415				
Box	th cer endir r use	N/UE	23b. was decedent pregnant	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal			23d. Date of delivery Month Day Year
	deal dealt	SICIO	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de 9 Unknown	eath 5 Other (specify)		World Say 15a.
P.0	res that the de signed by the a be detached t	Phy	9 Unknown	established to death but not read	Alting in the underhand anyon in Part I	23e Did toba	acce use contribute to the cause of death?
s,	ires th signed		Part II. Other significant conditions of	entire dealing to dealine durinot resc	ulting in the underlying cause given in Part I.		2 □ No 3 □ Probably 4 □Unknown
orc	v requir been s should	eted	O I I	905/1/1	(July 1113	24- 115	Oth Mars subject findings subjects
Records,	The law ate has b page 2 s	Completed	1)ia betes	melliti	0 ,	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
al F			Chron	ic rend	failure	1 ☐ Yes 2	No 1 Yes 2 No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	ice 6 Other (Specify)
of	Phys r this ral di	.: To	1 Yes 2 160	28a. Date of Injury	28b. Time of 28c. Injury at	28d. Describe how	
on	ding I th. : After s funer	후	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work? M 1 Tes 2 No		
Division of	Attending Physician: or death. sctor: After this certification of the funeral director,	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
Ö	s afte al Dir	Certification:	4 Tromicos	Building, oto. (apoon)	**		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the fi	cal	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowiner: On the basis of examination	wledge, death occurred at the time, date and place tion and/or investigation, in my opinion, death occu	, and due to the cau	use(s) and manner as stated. te and place, and due to the cause(s)
	To the H within 24 To the F complete	Medical	one)	and manner stated.	29c. License number		d. Date signed (Month, Day, Year)
	To To	~	29b. Signature and title of certifier		N -		
	5		/ lues	, care	1) 2428	2 1	March 05, 2005
	(]	30. Name and address of person who	5 / 1 /	123a) (Type, Print) Charles &	LUXIII L	iu n
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	itule	JIMIZ	
	Regist		MAR 1 0 200	Description A.	Grank)		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of H rtificate of I			g. No.		
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	al	Mildred 4a. Facility Name (If not institution, gire	Ford)	4h City Town or	Location of Death	March	8 2005 4c. County of Deat	0.30F	
1	Examin	er	Morningside Hou		·		tt City		Howard	''	
	Funeral				ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry)	
	Director		218-28-9109	1 M 2 12 F	73 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 26	1931 Mary	yland	
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
	Mar Mar	tor	Maryland Howard		Columb:	ia				1 ☐ Yes 2√∑ No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?	
	23a	ai	5174-1 Brook W	ay			1044		U.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show my righty or other treumatic event, the Madical Examinal rural Le mullied at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give	No	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2🌠 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.	
00-	2 hour		15. Decedent's E	Year or Dates:	16a Dece	dent's Usual Occup	ation	White			
Maryland 21215-0036	withIn 72 iene. than na	Completed	(Specify only highest girls) Elementary/Secondary (0-12) 12	ade completed) College (1-4or	5+)	kind of work done o DO NOT use retired D-Owner	during most of work f)		Architectu	cal Lighting	
9	Hygi other	Be C	17. Father's Name (First, Middle, Las	")		0	18. Mother's Nam			<u> </u>	
ılan	uld be Aenta rrkad ritic ev	To B	Jasper Higgs				Mabe1	Gilbert			
ary	sho and h		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailie	ng Address (Street a	and Number or Run	al Route Number,	City or Town, State, 2	(ip Code)	
Σ,	and and markh			Husband)		-1 Brook			ryland 210		
Baltimore,	Pages 1 ent of H nt: If Ite ry or otl		20a. Method of Disposition 1 Burial 2 Cremation 3 1 Other (Special Content of the Conten		20b. Place of Disponsion Crestlawi	natory or other plac	:e)		Roc. Location - City or larriottsvi		
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lice	msee Moja	22	Name and Addres	ss of Facility	nes. Inc.		vland 21045	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	polications that cause	d the death. Do not ent					Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	One cause on each	metast	alre 1	ung (ancer		Onset and Death	
	/Medical		resulting in death)	Due to (or as	metasis a consequence of):	,		777.0			
	Examiner		Anemia								
1	od sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
V .	xecut and	Examiner	that initiated events resulting in death) Last	c Due to (or as	Due to (or as a consequence of):						
68760,	ificate be executed g physician and as the burial-transit	aiE	(- d							
687	ifficate g phy: as the	edicai		u							
P.O. Box	attendin for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year	
	uires that the disigned by the	d by Ph	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	. /	
ecor	law requir as been s 2 should	Completed						24a. Was ar autops	/ prior to d	topsy findings available completion of cause of	
<u> </u>	ician: The lav certificate has rector, page 2	Con						perform 1 Yes 2	death? PNo 1 □ Yes	2 🗆 No	
/ita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one	9)	Assisted	
of	ding Physician: The h. After this certificate h: funeral director, page	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D			4 Nuising nu	ome 5 Reside 28d. Describe ho	nce 6 Ø Other <i>(Spec</i> w injury occurred	City) (11.10)	
lon	Attending F r death. actor: After by the funer	atlor	1 ∠Natural 5 ☐ Pending 2 ☐ Accident investigation		a <i>y Year)</i> Injury		k? Yes 2 □ No				
Division of Vital Records,	after des Director in by th	Certification;	3 ☐ Suicide 6 ☐ Could not determine	286. Place of it	njury - At home, farm, str etc. (Specify)	eet, factory, office		28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Co			t of my knowledge, deat of examination and/or in tated.						
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	od. Date signed (Month	n, Oay, Year)	
	/	1	Sola	M	7	D50	18.10	. 1	nanch 9	2005	
	19	J	30 Name and address of person who Suzim Abdo	completed cause of	death (Item 23a) (Type	Print) Lu	· Clas	houll	March 9	1029	
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. Figure	trar's Signature	barle					

			1 - For State Registrar	State of Mary			nt of H	eaith and	-		0.05	07909
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, La. 4a. Facility Name (If not institution, girls of the control of the cont	CTEVT ve street and number) Nursing	Ce 1	1 ter 4b. City	D	Location of Dea	nore	Day 0 3 4c. Cour	2005 nty of Death	3. Time of Death 4:05 pm
	Funeral Director		219-60-7055 Usuel Residence of Decedent	1□ M 20XF 9:		Yrs. Months		Hours Min		v, Year) 1911	Cour	place (State or Foreign otry) A
	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23e or 28e-f ehow event, the Medical Examinat must be recilified at	Director	MD 10b. County N/A 10c. Street and Number		Balti		p Code			10g. Citizen o		Od. Inside City Limits 1 Yes 2 No
	death with	Funeral D	2052 Grinnalds Av	12. Was Decedent Ever	r in U.S.		21230		Specify Yes or No- nto Rican, etc.)	U.S.A. No. 14. Race - American Indian,		
9600	hours after ural', or Ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes	21 No	Specify:	no Hican, etc.)		llack, White, cify:Whit	
1215-	filed within 72 I Hygiene. Ither then "nat Int, the Medica	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		a. Decedent's Usu (Give kind of wo life. DO NOT u Ome Make:	of work done during most of working OT use retired)					vistry
Maryland 21215-0036	should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last John Patrick Wood						me (First, Middle, ne Clark			
	nd 2 sho alth and 27 Is m r treum		19a. Informant's Name/Relationship Timothy Fohs/Son					nd Number or A rail Co 13	ura <i>l Route Numbe</i> urt Unit	r, City or Tow 201	n, State, Zip	Code)
Baltimore,	Page: ment of ant: If i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special Service Lice	Removal from State N	leadov	of Disposition (Na. ery, crematory or di yridge Me Park	other place emori	03-	Date 07-2005	Dorsey		
Ba	permit. Departit Imports any Inj.		23a Part 1. Enter the disease, or con	9	death. Do	22. Name at Ambro 2719 I	se Fu Hammo	neraĺ H nds Fer	ome of Lary Rd. La	ansdowr ansdowr	ne ne MD	21227
N. S.	Pnysician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a co	N e V	tia son's	4	's eas				Approximate Interval Between Onset and Death
9,0928	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C									
P.O. Box 6	that the death certific ed by the attending p detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal deat	n 3 ⊟Ectopic p 5 □ Other (sp				23d. Date of delivery Month Day Year		
Records, F	v requires tha been signed should be det	by	Part II. Other significant conditions	contributing to death but no	ot resulting	in the underlying o	cause givei	n in Part I.		bacco use co es 2□No		e cause of death? ably 4 Zunknown
al Reco	The ate he page	Completed							24a. Was a autop. perfor	SV .	D. Were autop prior to con death? 1 \(\sum \text{Yes}	osy findings available inpletion of cause of
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	4∏ ED/O	utpatient 3 DC		. /	ath (Check only or			
Division of	Ilng Afte fune	ation: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea			28c. Injury Work	at Universing i	dome 5 ☐ Resid 28d. Describe h)
Divis	in Line	Certification:	2 Accident Investigation 2 Accident							n, State)		l Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medicai	29a. Certifier 1 V Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my miner: On the basis of exa and manner stated.	y knowledg imination a	e, death occurred nd/or investigation	at the time n, in my opi	e, date and place nion, death occi	e, and due to the curred at the time, c	ause(s) and n ate and place	nanner as sta , and due to	ated. the cause(s)
)	To t To t	×	29b. Signature and title of certifier	y mo		290	c. License	number	71	9d. Date sign	ed (Month, L	2005
16-	8		30. Name and address of person who	co detectause of death	(Item 23a) A V	(Type, Print)	, B	altim	ove 1	Narv	land	21227
	Sta Registr		31. Date filed (Month, Pay 1 Year) 20	05 Registrar's S	Signature	porte						<i>I</i>

			For State Registrar	State of Marylan	d / Depa		lealth and N	/lental Hy	giene 005	07994
	Dhusisi		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath Day Ye	3. Time of Death
	Physici /Medio		John Fladung					March	6, 200	
	Examin		4a. Facility Name (If not institution, given Prince George's		20	4b. City, Town, or Cheverly	Location of Death		4c. County of D	
				Hospital Cente		If Under 1 Year	If Under 24 Hrs.	0.000		George's
	Funeral Director		5. Social Security Number 6. S 219-42-4220	ex 7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da) Oct. 13	9. 1943 Lau	Birthplace (State or Foreign Country) 1rel,MD
	and W		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	ncation				10d. Inside City Limits
	Aaryli I sho	ō	MD Prince G			r Hills				1 Yes 2 No
	28a-	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citîzen of What	Country?
	3a or	0	6722 Darby Road			2078	84		United Sta	·
	death	nere	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba			14. Race - A	merican Indian,
9	or its	교	1 Never Married 2 Married	1 Yes 2 No 196	5-	1 □ Yes 2√ No	Specify:	nican, etc.)	Cassifu	/hite, etc.
8	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-1 show he Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates: 19	67	••				√hite ———————
ਨ੍ਹ	n 72 •nat	iete	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup: kind of work done o DO NOT use retired	during most of work	king	16b. Kind of Busine	ss/Industry
21215-0036	a within 72 hours after death with the Marylar Jone I than "natural", or items 23a or 28a-1 show I the Medical Examinat must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Meato		,		Private	
D	should be filed v nd Mental Hygle i marked other t umatic event, ID	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname)	
<u>la</u> r	uid be Aenta rked ric ev	To B	Martin Edward	Fladung			Claire	L1oyd		
Maryland	2 sho and lis mu is mu		19a. Informant's Name/Relationship (or, City or Town, Stat	
	es 1 and of Health f itam 27 r other tr		Alice Fladung/					-	s, MD 2078	
jore	if ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crei	sition (Name of matory or other plac :o1n Cemet	e)	2005	20c. Location - City Brentwood :	
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If itam 27 is marked othe any injury or other traumatic event, once.		'4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Liner							
Ba	Depa impo any ir		Lena foro						n Funeral ntwood, M	
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the deat one cause on each line.			g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death 1 day
	/Medical Examiner		resulting in death)	Due to (or as a conseq						
		-a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Hypotention Due to (or as a conseq	l uence of):					
V	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or Injury that initiated events	c. Advanced Ci	rrhosi	s of the	Liver			
ó	sician and burial-transit	Exa	resulting in death) Last	Due to (or as a conseq		or the	птуст			
8760,	± ≥ 9c	icai		d						
9	leath certitica attending ph	Physician/Med	IF FEMALE:	00. 1/ 7. 17.						
Вох	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta	Ideath 3□	Ectopic pregnancy			23d. Date of Month	delivery Day Year
P.O.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of d 9 Unknown	eath 5	Other (specify)				
	res that I		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	quires on sign	ed by	Colitis, Anemia					1 🗆 Y	′es 2 ☐ No 3 ☐	Probably **Dunknown
000	law requas been 2 should	ompleted						24a. Was	an 24b. Were	autopsy findings available
Ä		E O						autop perfor	med? death	
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Deal			
of \	hye this al di	2	1 ☐ Yes 2 Æ No	Hospital: 1★ Inpatient 2□			+ _ 11013111g 110		lence 6 Other (S	(pecify)
nc On C	ing Atte	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	/ at <br Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	deat deat stor: / the	licat	2 Accident investigation 3 Suicide 6 Could not b		ome farm str		105 2 110	28f Location /S	Street and Number or	Rural Route Number,
Ο		Certification;	4 Homicide determined	building, etc. (Specif	y)	oot, ractory, onto		City or Tow		7,555,57,557,
	To the Hospital of within 24 hours at To the Funeral D completely tilled in	edicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tim vestigation, in my o	ne, date and place, pinion, death occur	and due to the dired at the time, of	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	ro the vithin ro the comple	Me	29b. Signature and title of certifier	200		29c. License	number		29d. Date signed (Mo	onth, Day, Year)
	- >- 0		> X (Jan Or		D-3	45 25		03 -0	8-2005
	5+1		30. Name and address of person who William DuBoyo				e Road S	Suite B-	216 Bowi	e, MD 20716
	Sta	117	31. Date filed (Ment) Pay Year) 20	32 egistrar's Signa	ture		- Road D	,u	ZIO DOWIC	-, 110 20/10
	Registi	ar		105 Been	J. As	ack!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Arthur Garey 4:36 PM 1050 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** N/A HENES CTIMOR 8. Date of Birth (Month, Day, May 12, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□F 83 218-01-4148 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Neufical Examinations to notified at 1 ☐ Yes 2 XNo Baltimore Arbutus Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 Is marked other then "natural", or Items 23e or ury or other traumatic event, It. Medical Exam har must be re-21227 USA 1001 Downton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1941 If Yes, Give Year or Dates: 1945 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Shipping Industry Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Watts John Garey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 Pinedale Drive Baltimore, Maryland 21236 Arthur E. Garey Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If any injury or once. 03/09/05 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) o voscular d **Physician** Lacord <50 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner burial-transit Due to (or as a consequence of): Box 68760, use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After the Hospitel or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. License number 29b. Signature and title of certifier 0 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Date filed (Month) DAY Deal

gistrar's Signatur

2005

			. Decedent's Name (First, Middle, La	State of Maryland / I 23a&27 per me G84				2. Date of De			3. Time of Death
	ysiciai ledica	n	James Walter					Februa Februa	ary 2	5, 2005	
	amine		a. Facility Name (If not institution, given	e street and number)	4b	. City, Town, or	Location of Deat		4c.	County of Death	
2				Hospital Center 7. Age (In yrs. last bir	thday) If	Cheve Under 1 Year	erly If Under 24 Hrs	R Data of Ri		ince Ge	orge's place (State or Foreign
Fune			217-60-6580	A		onths Days	Hours Min.		1955	Newp	ort, Md.
7		⊢	Jsual Residence of Decedent	140.00.7							
larylar	Till Till Till Till Till Till Till Till		D.C.	10c. City, Tow Wash	ningto						10d. Inside City Limits 1 Yes 2 □ No
the M	notiffe	- ect	I/Oe, Street and Number	, aug		Of, Zip Code			10g. Citiz	zen of What Cou	
death with the Maryland	27	2	809 52nd Street,	N.W.		2001	19		U.S		
ē #	xaminarmi	by Fur	1. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates:		Decedent of His, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black	
5-0 72 ho	jeal i	eted	15. Decedent's E	ducation 16a.	. Decedent'	's Usual Occupa d of work done d	tion uring most of wo	nrking	16b. Kir	nd of Business/Ir	ndustry
21215-0036 and within 72 hours affigiene.	Sa Mes	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	iife. DO i Printe			•	D C	Govern	ment
d 2 filed y Hygie	ant, III	ပ္မိ -	17. Father's Name (First, Middle, Las		r inice	21	18. Mother's Na	me (First, Middle	1		ille i i c
rlan uld be Aental rked o	tic ev	To Be	John Goldring				Mary L.	Queen			
Maryland nd 2 should be file lih and Mental Hy 27 is marked oth	r trauma		19a. Informant's Name/Relationship Mary V. Goldring	Type, Print) g/Sister	9 52r ashing	ddress (Street and Street and Street	nd Number of R	urai Route Numb	er, City or	r Town, State, Zi	p Code)
or 1 ar of Heal item	othe	1	20a. Method of Disposition	20b. Place of	f Dispositio	n (Name of		Date		cation - City or T	
Page Thent c	ury or		1 ⚠ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	hemoval from State Saint Church	h Ceme	etery	31ic 03-	0/-05	New	port, M	aryland
Baltimore, permit. Pages 1 at Department of Heal Important: If item	any inj once.		21. Signature of Funeral Service Lice Wanda	, Bacon	3447	ame and Addres 7 14th S	s of Facility W • St., N.W	H. Bacoi I. Wash.	, D.C	. 20010	me, Inc.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death. Do one cause on each line.	not enter th	ne mode of dying	, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physic		ŀ	Immediate Cause (Final disease or condition resulting in death)	a Atherosclerotic	Card	liovascu	lar Dis	ease			Onset and Death
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760, Ite be execu	burial	cai E)	Toolsting in doubly cast	Due to (or as a consequence	ot):						
	9		•	d							
of Vital Records, P.O. Box 68 Physician: The law requires that the death certifica this certificate has been signed by the attending ph	detached for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		opic pregnancy her <i>(specify)</i>			2	23d. Date of deliv Month	very Day Year
S, P.O es that the igned by th	be deta	y P	Part II. Other significant conditions	contributing to death but not resulting i	in the under	rlying cause give	n in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ords equires en sig								1 🗆	Yes 2	No 3□Pro	bably 4 □Unknown
of Vital Records, Physician: The law requires t	N	Completed						24a. Was	psy ormed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
Vital Fidician: The certificate	or, pa	0	25. Was case referred to medical				26. Place of De	1 TYes	2 No	1 TYes	2 No
f Vi ysicia	direct	ToB	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 € R/Ou	utpatient 3	3□ DOA Othe	r.	Home 5□Res		Other (Speci	ity)
			27. Manner of Death 1 X Natural 5 □ Pending		Time of Injury	28c. Injury Work		28d. Describe	how injury	occurred	
Division Tor Attending after death. Director: After	the fu	cati	2 Accident investigation	00 Blace of laive. At home to			es 2□No	28f. Location	Street and	d Number or Pur	al Route Number,
in the Signature of the	filled in by the	Certification:	4 Homicide determined	building, etc. (Specify)	am, street,	ractory, oince		City or To	wn, State))	ar House Humber,
To the Hospital	=	dicai		hysician: To the best of my knowledge miner: On the basis of examination are and manner stated.							
Within To th	du .	Me	29b. Signature and title of certifier	A 11.		29c. License	number		29d. Date	e signed (Month,	Day, Year)
	DI		Mounts	completed cause of death (Item 23a)	(Type Dei-	OCM	Œ		Febr	uary 26	, 2005
100	13		30. Name and address of person who MAMJAMM	A. KORELL	(1) pe, Frin		n Stree	t Balti	more	, Maryla	and 21201
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signature							

G	21		1 - For Unpend Item 2	State of I 3a,27,28a	Maryland a-f per	/ Depa me G	artment of H 841 3-28- dificate of	lealth ar Death	nd Mental Hy s	giene 20	05	07997
	Observatoria.		1. Decedent's Name (First, Middle, La	st)				·	2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		VALERIE GUY							8, 2005	1041	3:15 P M
4	Examir		4a. Facility Name (If not institution, gire		·		4b. City, Town, o		Death	4c. County	of Death	
			Maryland General			4 5 ° 4 ' 1 ' 1	Baltin		Hea la a la la			
	Funeral Director		213-90-2752	Sex 7. 1 □ M 2XXF	Age (In yrs. las	Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Da	th ly, Year) 24,1967	9. Birthp Cour	lace (State or Foreign try) MD
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d, Inside City Limits
	Marylan f ahow	ō	MD		DAT	ттмот) F			1 💆 Yes 2		
	r 28a	rec	10e. Street and Number		DAL	TIMOH	10f. Zip Code			10g. Citizen of V	Vhat Cour	itry?
	h with	Funeral Director	2341 DRUID HILL	AVENUE			2121	7		USA		
	deat	ner	11. Marital Status	12. Was Decede		13.	Was Decedent of H	ispanic Origin	n? (Specify Yes or No	- 14. Rac	e - Americ	
9	or Ite	F	1 XNever Married 2 ☐ Married	1 Tes 2		-	If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☒ No Specify:			Specify	k, White,	etc.
8	72 hours after death with the Maryland netural', or tlems 23e or 28a-1 ahow alres Evacilizer must be notified at	d by	3 Widowed 4 Divorced	Year or Date							BLA	
215-0036	n 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most a	of working	16b. Kind of Bu	ısiness/ind	dustry
212	within ione.	m o	Elementary/Secondary (0-12)	College (1-4	or 5+)		ITRESS	-,		RFST	AURAN	īT
	il Hygie other	Be C	17. Father's Name (First, Middle, Last)			LIKEDD	18. Mother's	s Name (First, Middle,			\ <u>1</u>
Maryland	should be and Mental a markad c umatic eve	To E	HARRY W. GUY				:	STE	PHANIE ANI	REWS		
lan	2 sho and l		19a. Informant's Name/Relationship						or Rural Route Number			
	l and lealth im 27 her ti		HARRY W, GUY/FA	THEK	OOb Bloo		SIDNEY A	VENUE	BALTIMORE			21230
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Important: If item 27 Is marked other than "netural", or Items 23e or 28a-1 ahov any Injury or other traumatic event. It a Medical Eventiret must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3		ite cem	etery, cren	natory or other plac	· 1	Date	20c. Location -	•	
Ħ	it. Pa rtmer rtant njury		* 4 □ Donation * 5 □ Other (Special Signature of Funeral Service Lice		MET		REMATORY		3-10-2005			MARYLAND
Ba	permit. Departr Imports any inj		Class & C	m.	-				ST. BALT			F.H., INC.
-	100		23a. Part Enter the disease, or con	plications the caus	sed the death.							Approximate
-	Physician		shook, or heart failure. List only Immediate Cause (Final	Cocaine	And Nar	çotiç	Intoxica	ation A	Associated	With	ļ	Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)		as a consequer		errar 10	ISIIS				
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687		edical		d								
Вох	leath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			ie			23d. Dat	e of delive	ry
	deati	slcla	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 ☐ Fetal de tat time of deat]Ectopic pregnancy] Other <i>(specify)</i>			Mor	nth	Day Year
P.0	res that the de signed by the a be detached f	Physician/M	9 X Unknown									
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant conditions	contributing to deat	h but not resultii	ng in the ur	nderlying cause giv	en in Part I.				e cause of death?
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ā	ricien: The lav certificate has rector, page 2	e Co	25. Was case referred to medical					00 01	1 Yes	2□No 1		2□ No
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1 0 f	ding Phys		27. Manner of Death	28a Date of I	niuny 26	Bb. Time of				now injury occurr		nk
joi	uttandin death. ctor: Afr / the fur	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigation		2:	und ^y 29		Yes 2 XNo				
Division	r Atti	Certification:	3 ☐ Suicide 6 🗶 Could not be determined		Injury - At home etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Numbern, State) 2112	or Rural	Route Number, Ave
Ω	urs af eral D			Scene					#15, Bal	timore,	Ma	
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: Atte completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Pl 2 ☒ Medical Exa	nysician: To the be miner: On the basis and manner	s of examination	edge, death n and/or inv	occurred at the ting restigation, in my o	ne, date and pointion, death	place, and due to the o occurred at the time,	cause(s) and mad date and place, a	nner as stand and due to	ated. the cause(s)
	To the comp	Σ	29b. Signature and title of certifier		-		29c. Licenso			29d. Date signed		
) (, Net	1	I him his	, m.D			OCI	ME ———		March 9	, 20	05
	10/1		30. Name and address of person who		of death (Item 23	3a) (Type,	•	~				
			LING LI, 31. Date filed (Month, Day, Year)	74 · 12	strar's Signature	θ	III Pei	m Stre	eet Balti	more, Ma	ryla	nd 21201
	Sta Registi		MAD 1 0 2		-		and a					

			Si Si	ate of Maryland		tment of H			riene.	
			For State Registrar	ato of Maryland	-	ificate of L			Reg. No.	07998
	o		Decedent's Name (First, Middle, Last)	_				2. Date of Dea	ath	3. Time of Death
E	Physicia /Medic		Billy	SANN				Month	Day Yea	- 77 2 3 M
	Examin		4a. Facility Name (If not Institution, give stree	t and number)		4b. City, Town, or	Location of De	eath	4c. County of De	
			LAVAL REGIONAL	40501 43		LAU	~e(Prince	Leorges
	Funeral		5. Social Security Number 6. Sex	7. Agel (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Hrs. 8. Date of Birt (Month, Da Mar 03,	y, Year) 9. 6	irthplace (State or Foreign Country) \$1ahoma
Н	Director		568-34-6128 Usual Residence of Decedent	/4				Mai US,	1931 0	Clanoma
	yland		10a. State 10b. County	10c. City, T	own or Loca	ation				10d. Inside City Limits
	Ba-f s	ctor	MD Anne Arunde	el Laur	el					1 □Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural; or Itams 23a or 28a-f show the than "badical Examinar must be multified at int, the Medical Examinar must be multified at	Director	10e. Street and Number			10f. Zip Code 20724			10g. Citizen of What	Country?
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	itam itam	Funeral	1	vas becedent Ever in o.s. Armed Forces?	IS. W	Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)	Black, W	
936	urs af	þ		f Yes, Give ∕ear or Dates: 1950−5	4	☐Yes 2☐XNo	Specify:		Specify:	White
Š 2	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade co.		6a. Decede	ent's Usual Occupa	ation during most of	workina	16b. Kind of Busines	-
2	Athin and the Mer	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		ind of work done of NOT use retired,			Washington	
2	filed w Hygien ther th		12 17. Father's Name (First, Middle, Last)		POTIC	e Office		Name (First, Middle,	Police De	Darchenc
and	d be f	Be c	Luther Gann					ae Jacksor		
Maryland 21215-0036	2 should and Men is marke sumatic	To	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing	Address (Street a	and Number or	Rural Route Number	er, City or Town, State	, Zip Code)
	C1 00 -20 00		Joan Gann /spouse		3367	Old Line	Avenue	e, Laurel,	Maryland	20724
ore,	es 1 and of Health fitam 27 r other tr		20a. Method of Disposition 1 □ Burial 2 ☒Cremation 3 □ Remo	20b. Place ceme	e of Disposi etery, crema	ition (Name of atory or other place	θ)	Date	20c. Location - City	or Town, State
Baltimore,	permit. Pages Department of I Important: If Its any injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)	W. A	runde	1 Cremat	ory Ma	r 10, 05	Odenton,	Maryland
3alt	Departi Departi Import any inj once.		21. Signature of Funeral Service Licensee		Do	Name and Addres	Funeral	L Home, P.	Α.	
	G □ ≒ e 0		A My Africally	M0077					Maryland 2	0707-4389 Approximate
			23a. Part I. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final	ause on each line.	Do not ente	٠.			riest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequent		Isch.	emi	4		
	Examiner			Sem ()	100 01).					
Ļ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or an il consequen	ice of):					
	cuted nd transi	Examiner	that initiated events							
,092	tte be executed sysician and ne burial-transit	I Ex	resulting in death) Last	Due to (or as a consequen	ice of):					
687	9 % 6	dical	d							
9 X	certifi ding	/Me	IF FEMALE: 23c.	f yes, outcome of pregnancy	y				23d. Date of	delivery
Box	d for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the death certific ed by the attending p detached for use as	Physician/Med	9 Unknown	9□ Unknown						
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by P	Part II. Other significant conditions contrib	uting to death but not resulting	ng in the un	derlying cause give	en in Part I.			lo the cause of death?
ğ	w require been sign	ted	Hypertersion					_ 1□'	Yes 2□No 31×2	Probably 4 □Unknown
ecc	e faw r has be je 2 sh	Completed	Emphysena					24a. Was autop	osy prior t	autopsy findings available completion of cause of
Vital Records,	: The cate h	Con				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 ☐ Yes	rmed? death 2 No 1 ☐ Y	
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	ital:		Othe		Death (Check only o		
of	ding Physician: The In. h. After this certificate ha funeral director, page	. To	1 Yes 2 Dolo	8a. Date of Injury 28	3b. Time of	3 DOA Othe	4 □ Nursir		dence 6 Other (S	Decity)
lon	Attending r death. actor: After	atior	1 Accident 5 Pending investigation	(Month, Day Year)	Injury		k? Yes 2 □ No			
Division	l or Attendi after death. Diractor: A	Certification:	3 Suicide 6 Could not be determined	8e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Street and Number or	Rural Route Number,
ō	ital or A rs after al Dirac	Cer		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	edical	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination	edge, death n and/or inve	occurred at the time estigation, in my op	ne, date and pl pinion, death c	lace, and due to the occurred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	thin 2 the the omplei	Med	29b. Signature and title of certifier	and manner stated.		29c. License	e number		29d. Date signed (Mo	onth, Day, Year)
	F 3 F 3		Hungen	us ERM	les di-	0	412-	20	Ma/ 9	. 2005
	α		30. Name and address of person who comp			Print))	3510	, ~	
	- X		Hound J. Mo	1(1s, no	73	UD VA	1 10/	en Rd	Unel,	, 2005 nd 20707
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signatur	Ө	P 100			•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 5 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** MARCH ROSEMARY C. GOTSCH 12005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS @ MERCY HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 🗆 M Yrs. Director 136.54.3914 93 AUGUST 16,1911 N.T Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examinar must be notified at Director 1 Yes ANNE ARUNDEL MD SEVERNA PARK 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 SEVERN AVE 21146 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ★ vidowed 4 □ Divorced XX WHITE . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Pages 1 and 2 should be filed nent of Health and Mental Hyginnt; if Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM HERON ဂ **ELEANOR MCMULLEN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES J. GOTSCH 120 SEVERN AVE SEVERNA PARK MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. ST. CATHERINE'S CEM 3.12.2005 WALL TWP, NJ e of Funeral Service Lic rise 22. Name and Address of Facility MARYLAND MORTUARY SUPPORT GREGORY FINK MO1148 K. 426 CRAIN HWY SW GLEN BURNIE MD 21061 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PAILE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter U. 37 ying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use co i ute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 ☐ Yes 2 Z No 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manper of Death 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riseberg

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 0 2005

Baltimore

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2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death March 4, Year 2005 **Physician** Marceline June Gagne 8:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Catonsville 158 Cherrydell Road Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Balt. MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F 213-26-5373 74 **Director** 4-12-1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County , or Items 23e or 28e-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No by Funeral Director Catonsville Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21228 158 Cherrydell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1□Yes № No Specify: white Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: white 3 ☐ Widowed 4 N Divorced netural Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home of Health and Mental Hygie fitem 27 is marked other t ir other treumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Beall ၉ Louis James Bonneville 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a 3657 Greenvale Road Violetville, Maryland 21229 Paticia Gagne- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery March 8, 05 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Furneral Home 21. Signature of Funeral Service I permit. 3620 Wilkens Ave. Baltimore, Maryland 21229 HIMANI gu Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Physician nancer 6 mo Dancheatic /Medical Due to (or as e consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. the attending physicien Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day ō 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 🗌 Yes 2 **N**0 3 Probably 4 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 certificate 2 No 1 Yes Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural the Hospital or Attending Injury 5 Pendina after death. 1 ☐ Yes 2 No investigation 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funerel L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03292 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Que BATIMORE MO 2122 grolen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 10